Patient Registration
(Newborn- 17-years)

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling Names and Ages *(ex: Jack, 9)*: _____

_____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: _____

PRIMARY FAMILY PHONE: (_____) _____ (*OFFICE USE: LABEL AS "MAIN")*

Parent Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (___) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Parent Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (___) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Alternate Contact (relative or friend): _____

Alternate Contact Phone: (_____) _____

Relationship to patient: _____

FORM COMPLETED BY:

Name *(print)*: _____

Signature: _____ **Date:** _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you.

Preferred Doctor/ARNP:

_____

Preferred Language:

_____

Your Child's Race
(select one primary)

- ☐ American Indian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other _____
- ☐ Decline to answer

Your Child's Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown
- ☐ Declined to answer

Please confirm your contact information is correct. We use this information to contact you about appointments, alerts, general health information, PHCA news and services, as well as payments and billing matters.

***** Please return this form to the Front Desk before leaving the office. Thank you. *****