Patient Registration Form
18 Years and Older, Foster

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

Today's Date: _____

Patient Information

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Mobile phone: _____ Email: _____

Parent/ Foster Parent Information

Parent Name: _____ Date of Birth: _____

Mobile Phone: ( )_____ Work Phone: ( )_____

Insurance Carrier Information

Insured's Name: _____ Date of Birth: _____

Name of Insurance: _____

Home Address (if different from patient): _____

City: _____ State: _____ Zip: _____

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/APRN:

_____

Preferred Language:

_____

Your Child's Race
(select one primary)

☐ American Indian or Alaskan Native
☐ Asian
☐ Black/African American
☐ Middle Eastern or North African
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other _____
☐ Decline to answer

Your Child's Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

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. **