PEDIATRIC HEALTH ASSOCIATES

PATIENT INFORMATION

	FIRST CHILD	SECOND CHILD	THIRD CHILD	FOURTH CHILD
FIRST NAME				
LAST NAME				
DATE OF BIRTH				
SEX	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
Primary Language				
Ethnicity	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Decline	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Decline	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Decline	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Decline
Race	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Decline	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Decline	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Decline	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Decline

PATIENT ADDRESS

Address:

City, State, Zip:

Mail Statements to this address? ☐ Yes ☐ No

PRIMARY PHONE: **IS THIS A CELL PHONE?** ☐ Yes ☐ No

Okay to receive messages through MyChart for non-urgent results ☐ Yes ☐ No

CONTACT INFORMATION

FIRST CONTACT (PARENT/GUARDIAN)	**SECOND CONTACT (PARENT/GUARDIAN)**
Last Name:	Last Name:
First Name:	First Name:
Relationship: DOB:	Relationship: DOB:
Address:	Address:
City, State, Zip:	City, State, Zip:
Email address:	Email Address:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Are you the primary insurance carrier? ☐Yes ☐ No	Are you the primary insurance carrier? ☐Yes ☐ No
Are you the primary contact? ☐Yes ☐ No	Are you the primary contact? ☐Yes ☐ No