advocare

☐ New Patient ☐ Edit Information

Pediatric Family Registration Form

This form can be used for all children UNDER the AGE of 18

Please complete this form to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Child #1 Last Name: _____ First: _____ MI: _____
Preferred Name: _____ Date of Birth: _____
Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
Minor's Cell Phone: _____

Child #2 Last Name: _____ First: _____ MI: _____
Preferred Name: _____ Date of Birth: _____
Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
Minor's Cell Phone: _____

Child #3 Last Name: _____ First: _____ MI: _____
Preferred Name: _____ Date of Birth: _____
Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
Minor's Cell Phone: _____

Child #4 Last Name: _____ First: _____ MI: _____
Preferred Name: _____ Date of Birth: _____
Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
Minor's Cell Phone: _____

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Declined to specify

Race:
☐ American Indian/Alaska Native ☐ Asian
☐ African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Declined to specify

Preferred Language:
☐ English ☐ Spanish
☐ Other: _____

Translator?
☐ YES ☐ NO

Comments: _____

Family's Primary Address

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____

Provider Information

Complete this section if applicable.

Primary Care Provider:
Name: _____
Address: _____
_____
City, State, Zip: _____
Phone: _____
Fax: _____

Referring Provider:
Name: _____
Address: _____
_____
City, State, Zip: _____
Phone: _____
Fax: _____

Patient's Reminders/Communication

This section is related to communication and Patient Portal access. (See 'Patient Portal FAQs')

Please provide the contact information for the person who is to receive the reminders/communication for the patient(s).

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

☐ Web Enabled Patient E-Mail: _____
(must be patient's email if over age 12)

☐ No Email ☐ Patient Refused Parent/Proxy E-Mail: _____

☐ Voice Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work
☐ Text Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:
☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ ALL ☐ NONE

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: _____

_____

Patient's Parental Information

Patient lives with ☐ Both Parents ☐ Parent A ☐ Parent B ☐ Guardian*

Custody Agreement ☐ YES ☐ NO ☐ N/A (If YES, please provide copy)

Parent/Guardian (A) Name: _____

Cell Phone: _____

Parent (A) Address same as patient ☐ YES ☐ NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Parent (A) Date of Birth: _____

Home phone: _____

Email Address: _____

Employment Status:

☐ Employed FT ☐ Employed PT ☐ Not Employed

☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt

Employer: _____

Other please explain: _____

*If YES to Guardian, please provide court documents

Parent/Guardian (B) Name: _____

Cell Phone: _____

Parent (B) Address same as patient ☐ YES ☐ NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Parent (B) Date of Birth: _____

Home phone: _____

Email Address: _____

Employment Status:

☐ Employed FT ☐ Employed PT ☐ Not Employed

☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt

Employer: _____

Emergency Contact Information

(please provide contact other than parents)

Last Name, First Name: _____ Relationship to Patient: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance

☐ Self-Pay (no insurance) Patient insured under: ☐ Mother's Insurance ☐ Father's Insurance ☐ Other

☐ Medicaid – ID Number: _____

PRIMARY INSURANCE NAME:

Benefit Plan Name: _____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

PCP listed on card: _____

SECONDARY INSURANCE NAME:

Benefit Plan Name: _____

Member ID: _____ Group#: _____ Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

PCP listed on card: _____

Guarantor Information

Guarantor must initial to acknowledge that you are aware that you will receive the bill and be financially responsible for this patient. Guarantor Initial: _____

Relationship: ☐ Father ☐ Mother ☐ Other (specify): _____

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

Address: _____

City, State, Zip: _____

Home phone: _____ Cell Phone: _____ Email: _____

Guarantor's Employer: _____

Work phone: _____

Address: _____

City, State, Zip: _____