advocare

Child Registration Form

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

☐ New Patient ☐ Edit Information

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

Patient Information

Patient Last Name: _____ First: _____ MI: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____

Minor's Cell Phone: (_____) _____ ☐ None

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

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: _____

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 this patient.

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* Other please explain:

Custody Agreement ☐ YES ☐ NO ☐ N/A (If YES, please provide copy) *If YES to Guardian, please provide court documents

Parent/Guardian (A) Name: _____	**Parent/Guardian (B) Name:** _____
Cell Phone: _____	Cell Phone: _____
Parent (A) Address same as patient ☐ YES ☐ NO	**Parent (B)** Address same as patient ☐ YES ☐ NO
If NO- please complete	If NO- please complete
Addr: _____	Addr: _____
City, State, Zip: _____	City, State, Zip: _____
Parent (A) Date of Birth: _____	**Parent (B)** Date of Birth: _____
Home Phone: _____	Home Phone: _____
Email Address: _____	Email Address: _____
Employment Status:	**Employment Status:**
☐ Employed FT ☐ Employed PT ☐ Not Employed	☐ Employed FT ☐ Employed PT ☐ Not Employed
☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt	☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt
Employer: _____	**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: _____