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 _____

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: _____

Primary Care Provider:

Name: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

Referring Provider:

Name: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

Patient's Primary Address

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____

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: _____