advocare

Pediatric Family Registration Form

☐ New Patient ☐ Edit Information

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: _____

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 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 ☐ Mom ☐ Dad ☐ Guardian*

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

Mother's Name: _____

Cell Phone: _____

Mother Address same as patient ☐ YES ☐ NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Mother's 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

Father's Name: _____

Cell Phone: _____

Father Address same as patient ☐ YES ☐ NO

If NO- please complete

Addr: _____

City, State, Zip: _____

Father's 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: _____