



# Welcome to ProHEALTH Care Associates, LLP.

## PATIENT REGISTRATION FORM

### PEDIATRICS

In order to serve you, we need the following information. Please print.

Today's Date: \_\_\_\_\_ **Thank you for selecting ProHEALTH Care Associates.**

#### PATIENT INFORMATION

Patient's Last Name:		First:	Middle:	Gender:	Age:	Birth Date:
Social Security No.:		Preferred Language:		Home Phone No.:		Student: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time
Race: <input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		Ethnicity: <input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Asian	<input type="checkbox"/> White		<input type="checkbox"/> Decline to Answer		<input type="checkbox"/> Decline to Answer	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Two or More Races					
Street Address:			City/Town:		State:	Zip Code:

#### MOTHER/GUARDIAN

Last Name:		First Name:		Middle Initial:	Gender:	Age:	Birth Date:
Maiden Name:		Mobile Phone No.:			Social Security No.:		
Employer:		Work No.:		Email Address:			
Street Address:			City/Town:		State:	Zip Code:	

#### OTHER PARENT/GUARDIAN

Last Name:		First:		Middle:	Gender:	Age:	Birth Date:
Mobile Phone No.:		Work No.:			Social Security No.:		
Employer:		Street Address:			City/Town:		
State:	Zip Code:	Email Address:		Relationship to Patient: <input type="checkbox"/> Father <input type="checkbox"/> Other: _____			

#### EMERGENCY CONTACT

Name of Relative (not living at the same address):		Relationship to Patient:	
Primary Telephone No.:		Secondary Telephone No.:	

#### SIBLINGS

Name:	Date of Birth: _____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name:	Date of Birth: _____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name:	Date of Birth: _____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name:	Date of Birth: _____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN
------------------------	---------------------

Primary Care Physician Name:		Referring Physician (if not same as PCP):	
Street Address:		Street Address:	
City, State, Zip:	Telephone No.:	City, State, Zip:	Telephone No.:

Please provide the name/s and telephone numbers of any other doctors treating the patient at this time.

#### PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone No.:
		Fax No.:

**INSURANCE INFORMATION**

<b>PRIMARY INSURANCE</b>	Insurance Name:	Claims Address:	Group No.:
	Telephone No.:		ID No.:
	Insured's Name:	Insured's S.S. No.:	Birth Date:
<b>SECONDARY INSURANCE</b>	Insurance Name:	Claims Address:	Group No.:
	Telephone No.:		ID No.:
	Insured's Name:	Insured's S.S. No.:	Birth Date:

**NO FAULT INFORMATION****You must complete this section if the patient was involved in a Motor Vehicle accident.**

Date of Accident:	Insurance Carrier Name:	Address:
Policyholder's Name:	Policy No.:	Claim No.:
Relationship to Insured:	Claims Adjuster:	Telephone No.:
Briefly describe how and where patient's injury occurred:		

**ATTORNEY INFORMATION - For No Fault**

Law Firm Name:	Address:	Name of Attorney Handling Case:	Telephone No.:
			Fax No.:

**AUTHORIZATION FOR RELEASE OF INFORMATION BY ProHEALTH Care Associates, LLP**

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize ProHEALTH Care Associates, LLP to furnish all records and results to the parties I specify.

**PARENT/GUARDIAN PRINT NAME:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

**PARENT/GUARDIAN PRINT NAME:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_