ProHEALTH℠ Care

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:	Date of Birth:

Patient's Address:	Apt#:	City/Town:	State:	Zip Code:

Home Telephone Number:	Preferred Language:	Student: ☐ Part Time ☐ Full Time

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

PARENT/GUARDIAN#1

Parent/Guardian's Last Name:	First Name:	Middle Initial:	Gender:	Age:	Date of Birth:

☐ Check here if patient lives with this parent/guardian	Relationship to Patient:

Street Address: (Leave blank if same as patient)	City/Town:	State:	Zip Code:

Home Telephone Number:	Work Telephone Number:	Cell Phone Number:	Email Address:

Mother's Maiden Name:

PARENT/GUARDIAN#2

Parent/Guardian's Last Name:	First Name:	Middle Initial:	Gender:	Age:	Date of Birth:

☐ Check here if patient lives with this parent/guardian	Relationship to Patient:

Street Address: (Leave blank if same as patient)	City/Town:	State:	Zip Code:

Home Telephone Number:	Work Telephone Number:	Cell Phone Number:	Email Address:

EMERGENCY CONTACT

Name of Person:	Relationship to Patient:
Telephone Number:	Additional Contact Number:

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone Number:
		Fax Number:

SIBLINGS

Name:	Date of Birth: _____/_____/_____	☐ Male ☐ Female
Name:	Date of Birth: _____/_____/_____	☐ Male ☐ Female
Name:	Date of Birth: _____/_____/_____	☐ Male ☐ Female
Name:	Date of Birth: _____/_____/_____	☐ Male ☐ Female

PRIMARY INSURANCE INFORMATION

Insurance Company Name:	Claims Address:	Telephone Number:

ID Number:	Group Number:

Policyholder's Name:	Date of Birth:

Employer Name:	Work Telephone Number:

Employer's Address:	City/Town:	State:	Zip Code:

SECONDARY INSURANCE INFORMATION

Insurance Company Name:	Claims Address:	Telephone Number:

ID Number:	Group Number:

Policyholder's Name:	Date of Birth:

Employer Name:	Work Telephone Number:

Employer's Address:	City/Town:	State:	Zip Code:

PARENT/GUARDIAN PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____/_____/_____