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:

Street Address:	City/Town:	State:	Zip Code:

Social Security No.:	Home Phone No.:	Student: ☐ Part Time ☐ Full Time

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: ☐ Mother ☐ Father ☐ Other:_____

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

PHARMACY INFORMATION

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

INSURANCE INFORMATION

PRIMARY INSURANCE	Insurance Name:	Claims Address:	Group No.:
	Telephone No.:		ID No.:
	Insured's Name:	Insured's S.S. No.:	Birth Date:

SECONDARY INSURANCE			
	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: _____/_____/_____