ChristianaCare™

PATIENT REGISTRATION FOR MINORS

PATIENT INFORMATION

Name (Last): _____ (First): _____ (Middle): _____

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III ☐ IV Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ /_____ /_____ Email address (if 12 years old or greater):_____

Phone: Home: (_____) _____ Cell: (_____) _____ Preferred: ☐ Home ☐ Cell

Patient SSN: _____ Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other race:_____
☐ More than one race ☐ Declined/Not available

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined/Not available

Preferred language: ☐ ASL ☐ Arabic ☐ English ☐ Hindi ☐ Korean ☐ Mandarin ☐ Spanish
☐ Other:_____

PARENT/GUARDIAN INFORMATION

Parent/guardian name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: (_____) _____ Work: (_____) _____
Cell: (_____) _____ Preferred: ☐ Home ☐ Work ☐ Cell

Parent SSN: _____ Date of birth: _____ /_____ /_____ Gender: ☐ Male ☐ Female

Preferred language:_____

Parent/guardian name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: (_____) _____ Work: (_____) _____
Cell: (_____) _____ Preferred: ☐ Home ☐ Work ☐ Cell

Parent SSN: _____ Date of birth: _____ /_____ /_____ Gender: ☐ Male ☐ Female

Preferred language:_____

Responsible party (party responsible for payment): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Name (Last): _____ (First): _____ Date of birth: _____ /_____ /_____

Primary care provider: _____ Phone#: (_____) _____

Preferred Pharmacy: _____ Phone#: (_____) _____

COMPLETE SIDE 2

ChristianaCare™

PATIENT REGISTRATION FOR MINORS

INSURANCE INFORMATION

Primary insurance:_____ Relationship to patient:_____

Insurance company: _____ Date of birth: _____ /_____ /_____

Insurance address: _____

City: _____ State: _____ Zip: _____

Policy ID#: _____ Group ID#: _____

Secondary insurance: _____ Relationship to patient:_____

Insurance company: _____ Date of birth: _____ /_____ /_____

Insurance address: _____

City: _____ State: _____ Zip: _____

Policy ID#: _____ Group ID#: _____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ Relationship to patient: _____

Phone: Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____ Preferred: ☐ Home ☐ Work ☐ Cell

Emergency contact: _____ Relationship to patient: _____

Phone: Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____ Preferred: ☐ Home ☐ Work ☐ Cell

_____	_____	___/___/___	_____
Parent/Guardian Signature	Relationship to Patient	Date	Time

Interpretation: The information has been presented to the: ☐ patient ☐ representative ☐ decision maker in: _____ Language

The person who provided the interpretation is a qualified medical interpreter.

_____	_____
Interpreter Name	Agency and ID# (if applicable)

_____	_____	___/___/___	_____
Witness Signature	Print Name	Date	Time