CHRISTIANA CARE
HEALTH SERVICES

Patient Registration

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

Address:_____

City:_____ **State:**_____ **Zip:**_____ **Country:**_____

Birth Date:_____ **Email address:**_____

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

Contact By: ☐ Phone ☐ Mail ☐ Cell **Preferred Language:**_____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **SSN:**_____
☐ Separated ☐ Civil Union ☐ Other: _____

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

Employment Status (mark all that apply): ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired
☐ Student ☐ Child ☐ Unemployed ☐ Other: _____

Primary Care Provider:_____ **Phone:**_____

Preferred Pharmacy:_____ **Phone:**_____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

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

Name: (Last):_____ **(First):**_____ **Birth Date:**_____

SSN:_____ **Sex:** ☐ Male ☐ Female

Address:_____

City:_____ **State:**_____ **Zip:**_____ **Country:**_____

Phone:_____ **Work:**_____ **Fax:**_____ **Email:**_____

Primary Insurance:_____ **Effective Date:**_____

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ **ID#:**_____ **Group#:**_____

Subscriber Name: (Last):_____ **(First):**_____ **Birth Date:**_____

Secondary Insurance:_____ **Effective Date:**_____

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ **ID#:**_____ **Group#:**_____

Subscriber Name: (Last)_____ **(First)**_____ **Birth Date:**_____

Signature of Patient or Representative	Relationship to Patient	Date	Time
		__/__/__	

Interpretation: The information presented orally to the ☐ patient ☐ representative ☐ decision maker was interpreted into (language): _____. The person for whom the information was interpreted stated s/he understood the interpretation.

Interpreter Name	Agency and ID# (if applicable)

Staff Signature/Title	Print Name or ID#	Date	Time
		__/__/__	

CHRISTIANA CARE

Communication Authorization Form

Office name Christiana Care Pediatric Associates
Address street 4735 Ogletown Stanton Road
MAP II Suite 1116
City State zip Newark, DE 19713

Primary Care Provider:

Patient Name:
Date of Birth:
Centricity #:
SMS #:
MRN # :

Patient Name: (print) _____ **Date of Birth:**_____

My personal health care information is protected under the Health Care Information Privacy Protection Act (HIPPA). In order for health care professionals to communicate about my health with any other non-health care professionals related to my care, I must name those persons as authorized to receive information about me and my health care.

I authorize Christiana Care to communicate my health information to person(s) of my choice concerning my identity, diagnoses, treatments and financial status related to the following health care services:

☐ All information in my health care record at the Christiana Care Health System.

Or, if not all information, **please check specific items that we may share with authorized persons.**

☐ Behavioral Health- Mental Status, Substance Abuse	☐ Genetic	☐ Other Specialty Care: _____
☐ Cancer	☐ HIV	_____
☐ Diagnostic Tests – Lab, Blood, Xray, MRI, Mammogram, other Radiology	☐ Obstetrics and Gynecology – Pregnancy, other gynecology	_____
☐ Financial Status/ Billing Records	☐ Primary Care: Immunizations, preventive care, chronic conditions, treatment plans with primary care provider (PCP).	_____

Authorized Persons:

Name (please print clearly)	**Relationship**	**Phone number**

Expiration of this authorization:

This authorization does not expire. It is the responsibility of the patient to modify or revoke this authorization and may be done at any time. To modify or revoke this information please provide a written request to the office at Christiana Care listed at the top of this form; or, visit the office and request a change in Communication Authorization in person.

_____
Patient Signature **Date of Authorization**

_____
Witness Signature **Date of Authorization**

An electronic or photocopy of the signed communication authorization form is as valid as the original