

# Registration Form

Has the patient received services at Children's Hospital or any of our clinics?  Yes  No



200 Henry Clay Ave.  
New Orleans, LA 70118  
(504) 899-9511  
www.chnola.org

## Patient's Information

### Ethnicity (Please select one)

Hispanic or Latino  Not Hispanic or Latino

### Race (Please select one)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

### Primary Language

English  Spanish

Other

Last Name \_\_\_\_\_ Sex: M F

First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Religion \_\_\_\_\_

Street Address \_\_\_\_\_

P.O. Box (if applicable) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_

## Father's Information

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

E-mail address \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Single  Married  Divorced  Separated  Widowed

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

## Mother's Information

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

E-mail address \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Single  Married  Divorced  Separated  Widowed

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

## Person Responsible for Bill

Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Social Security No. \_\_\_\_\_

## Emergency Contact (Other Than Parent)

**Please list the name of a relative or friend that does not live with you and can be contacted in case of an emergency.**

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

## Insurance Information

### First Policy:

Insurance Company \_\_\_\_\_

Phone # to verify Insurance coverage ( ) \_\_\_\_\_

Policy # \_\_\_\_\_

Does your insurance need to be pre-certified?  Yes  No

Name of Insured \_\_\_\_\_

### Second Policy:

Insurance Company \_\_\_\_\_

Phone # to verify Insurance coverage \_\_\_\_\_

Policy # \_\_\_\_\_

Does your insurance need to be pre-certified?  Yes  No

Name of Insured \_\_\_\_\_

## Other Information

### Medicaid (Please present Medicaid Card):

Medicaid # \_\_\_\_\_

Parish \_\_\_\_\_

Name of Worker \_\_\_\_\_

Children's Special Health Services Program?  Yes  No

Parish \_\_\_\_\_

Name of Worker \_\_\_\_\_

## Referral Information

Child's Pediatrician \_\_\_\_\_

Who referred the patient to Children's Hospital? \_\_\_\_\_

Physician's Name \_\_\_\_\_

Health Facility's Name \_\_\_\_\_

## Office Use Only

Medical Rec. # \_\_\_\_\_

Acct. \_\_\_\_\_

Doctor \_\_\_\_\_

Service \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

