Children's Hospital
New Orleans
LCMC Health

REGISTRATION FORM

PAGE 1 OF 1

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

200 Henry Clay Ave. New Orleans, LA 70118 504.899.9511 • chnola.org

HAS THE PATIENT RECEIVED SERVICES AT CHILDREN'S HOSPITAL OR ANY OF OUR CLINICS? ❑ YES ❑ NO

Patient's Information

PLEASE PRINT • MUST BE LEGAL BIRTH NAME • THIS INFORMATION IS REQUIRED

Last Name_____Suffix_____
First Name _____ Middle _____
Date of Birth_____
Street Address _____
P.O. Box (if applicable)_____
City_____ State_____ Zip Code _____
Home Phone ( )_____
Cell Phone ( ) _____
Social Security # _____
Preferred language _____
Sex: ❑Male ❑Female

OPTIONAL: PLEASE SELECT ONE FROM THE FOLLOWING

Religion: _____
Ethnicity: ❑Hispanic / Latino ❑Not Hispanic / Latino
Race: ❑American Indian or Alaska Native
❑Asian
❑Black or African American
❑Native Hawaiian / Other Pacific Islander
❑White

Father's Information

PLEASE PRINT • MUST BE LEGAL BIRTH NAME • THIS INFORMATION IS REQUIRED

Last Name_____Suffix_____
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

PLEASE PRINT • MUST BE LEGAL BIRTH NAME • THIS INFORMATION IS REQUIRED

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

PLEASE PRINT • MUST BE LEGAL BIRTH NAME •THIS INFORMATION IS REQUIRED

Name _____
Relationship to Child_____ Phone _____
Employer _____
Address_____
City_____ State_____ Zip Code _____
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

Name of Insured _____
Insured Date of Birth: _____
Insured Social Security #: _____

FIRST POLICY:

Insurance Company _____
Phone # to verify Insurance coverage ( ) _____
Policy #_____
Does your insurance need to be pre-certified? ❑ Yes ❑ No

SECOND POLICY:

Insurance Company _____
Phone # to verify Insurance coverage ( ) _____
Policy #_____
Does your insurance need to be pre-certified? ❑ Yes ❑ No
Name of Insured _____

Medicaid/CCN Bayou Plan

Medicaid # _____
Parish/County_____ State _____
Name of Worker _____

Referral Information

Child's Pediatrician _____

Who referred the patient to Children's Hospital:
Physician's Name _____
Health Facility's Name _____

Parent/Guardian/Caregiver's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:

OFFICE USE ONLY

Medical Rec. #_____Acct. _____
Physician_____Service _____
Date_____ Time _____

ENCOUNTER LEVEL

ADMISSION APPROVAL FORM

CH1001/ PAC/REGISTR | (05/15, 02/20) Revised

EL103