THE P.A.T.C.H. CENTER

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Telehealth Patient Registration
(Please Print)

PATIENT INFORMATION

Today's date:	Email address:			
Child's last name:	First name:	Middle initial:	Birthdate:	Sex:
Legal name, if different than above:	Primary phone number:	Secondary phone number:	Social Security number:	
Address:				
Parent/Legal guardian name:	Parent/Legal guardian address:	Parent/Legal guardian phone number:		
Parent/Legal guardian date of birth:	School child attends:			
Does child receive free and/or reduced lunches: Yes No				

INSURANCE INFORMATION *(please have insurance card available to make a copy)*

Person responsible for bill:	Birthdate:	Phone:
Address of responsible party, if different than above:	Is responsible party a patient at Clarity/Preferred Family? Yes No	
Employer:	Employer address:	
Employer phone number:	Patient's relationship to insurance subscriber: Child Step-child Other	
Primary insurance: Medicare Medicaid Blue Cross/Blue Shield United Healthcare Other:		
Subscriber's name:	Subscriber's Social Security number:	Subscriber's birthdate:
Policy number:	Group number:	Co-payment amount:
Secondary insurance, if applicable: Medicare Medicaid Blue Cross/Blue Shield United Healthcare Other:		
Subscriber's name:	Subscriber's Social Security number:	Subscriber's birthdate:
Policy number:	Group number:	Co-payment amount:
Patient's relationship to insurance subscriber: Child Step-child Other:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Primary phone number:	Secondary phone number:

Please continue on next page.