2. Registration Form

Patient Information

Child's Name: Last Name: _____ First Name: _____ MI: _____

Date of Birth (MM/DD/YYYY) _____ Age: _____ Sex: ☐ Male ☐ Female

Child's Address:

Preferred Pharmacy: _____ Pharmacy Phone No: _____

Student Grade: _____

Parent/Guardian Information:

Name of Mother: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Mother's Email Address: _____

Name of Father: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Father's Email Address: _____

Name of Other Guardian: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Other Guardian's Email Address: _____

Best Emergency Contact (if the above can't be reached): _____

Relationship to child: _____ Phone: _____

Insurance Information: I hereby give my permission for Penn Highlands Healthcare to bill my insurance as follows:

Primary Insurance Information

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Policy Holder Name: _____

Policy Holder's Relationship to Child: _____

Policy Holder Date of Birth (MM/DD/YYYY): _____

Insurance ID: _____

Group Number: _____

Secondary Insurance Information

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Policy Holder Name: _____

Policy Holder's Relationship to Child: _____

Policy Holder Date of Birth (MM/DD/YYYY): _____

Insurance ID: _____

Group Number: _____