Arlington Pediatric Associates

Patient Name | Preferred Name | Date of Birth | Sex (M/F/T) | Preferred Pronouns

Home Address: No. Street City State Zip

PATIENTS 13 YEARS and OLDER
Patient Phone: _____
Patient Email: _____

ONLINE PATIENT PORTAL (MyChart)
☐ Yes, I want access to my MyChart
☐ No, I do not want access.

PARENT/GUARDIAN INFORMATION

Name Relationship to Pt	Name Relationship to Pt
Address	Address
Home Phone Cell Phone	Home Phone Cell Phone
Employer Work Phone	Employer Work Phone
Parent Email **(print clearly)**	Parent Email **(print clearly)**
ONLINE PATIENT PORTAL (MyChart) ☐ Yes, give me access. My D.O.B:_____ ☐ No, do not give me access	**ONLINE PATIENT PORTAL (MyChart)** ☐ Yes, give me access. My D.O.B:_____ ☐ No, do not give me access

PHARMACY

Pharmacy Name | Street Address (#) | City

INSURANCE AND PAYMENT INFORMATION

Insurance Name: _____

Subscriber: _____ Subscriber DOB: _____

Name of person responsible for balances unpaid by insurance if **NOT** subscriber:

Name: _____ DOB: _____

SIGNATURE (parent or patient if over 18) **DATE**

The categories listed below provide a minimum standard for maintaining, collecting and presenting data on race and ethnicity for Federal reporting purposes.

Race; Please check all that apply (up to 3):

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other, please Specify_____
- ○ Unknown
- ○ **Decline to Answer**

Ethnicity; Please check one:

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown
- ○ **Decline to Answer**

Preferred Language; Please check one:

- ○ English
- ○ Other, please specify:_____
- ○ **Decline to Answer**

Written Language; Please Check one:

- ○ English
- ○ Other, please specify:_____
- ○ **Decline to answer**

PATIENT NAME: _____ **DATE OF BIRTH:** _____