Star Registration Form

Appointment Date _____Appointment Time _____Provider _____

1) Has this child used another name? (AKA) _____ Yes ☐ No ☐

2) Has this child been Treated in a Clinic / ER or Hospitalized at CHLA _____Yes ☐ No ☐

PATIENT

PATIENT'S Last, & First Name	SEX ☐ M ☐ F	*DOB	RACE ☐ 1-Caucasian ☐ 2-African American ☐ 3-Nat American/Eskimo ☐ 4-Asian pacific ☐ 5-other	CHLA - MR#
MARITAL STATUS ☐ Single ☐ Married	PATIENT'S STREET ADDRESS		CITY, STATE, ZIP CODE	PATIENT'S HOME PHONE ( )
MOTHER'S MAIDEN LAST NAME	FATHER'S FIRST NAME	PT SSN #	RELIGION	
NATIONALITY ☐ 1-Hispanic ☐ 2-Non-Hispanic	LANGUAGE ☐ Armenian ☐ Cambodian ☐ Chinese ☐ English ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Spanish ☐ Vietnamese ☐ Other		EMPLOYMENT STATUS	

GUARANTOR (FINANCIALY RESPONSIBLE)

NAME	RELATION PARENT ☐ Nat. Mother ☐ Nat. Father ☐ Other	SEX ☐ M ☐ F	DOB	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ X-Sep ☐ Widow ☐ Life Partner
STREET ADDRESS	CITY, STATE, ZIP CODE		HOME PHONE NUMBER	
SOCIAL SECURITY #	EMPLOYMENT STATUS ☐ 1-FT ☐ 4-PT ☐ 6-Self-Empl. ☐ 5-Retired ☐ 2-Military Act on Duty	EMPLOYER'S NAME	EMPLOYERS TEL. #	
EMPLOYER'S ADDRESS	CITY, STATE, ZIP CODE	OCCUPATION	DRIVER'S LICENCE	

RELATIVE 1

NAME	RELATION TO PATIENT	SEX ☐ M ☐ F	SOCIAL SECURITY #	DOB
STREET ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE # ( )		

EMERGENCY CONTACT

NAME OF EMERGENCY CONTACT	RELATION TO PATIENT	HOME PHONE NUMBER ( )
STREET ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE #

PRIMARY INS

INSRUANCE CARRIER NAME	INSURANCE ADDRESS	TELEPHONE NUMBER ( )
MEDICAL GROUP/PLAN NAME	ADDRESS	TELEPHONE NUMBER ( )
SUBSCRIBERS NAME	RELATION TO INSURED	GROUP / POLICY #

SECONDARY INS

INSRUANCE CARRIER NAME	INSURANCE ADDRESS	TELEPHONE NUMBER ( )
MEDICAL GROUP/PLAN NAME	ADDRESS	TELEPHONE NUMBER ( )
SUBSCRIBERS NAME	RELATION TO INSURED	GROUP / POLICY #

Parent or Legal Guardian Signature: _____Date: _____