**OLD HARDING PEDIATRIC ASSOCIATES**
**PATIENT DATA FORM**

Today's Date ____________________

**Patient's Name**____________________________________________________________

Date of Birth_________________________ □ Male or □ Female

Residence Phone_________________________________

Patient's Address __________________________________________________

__________________________________________________

**Race** (Choose one)

□ American Indian/Alaska Native □ Asian □ Black/African American
□ Native Hawaiian/Pacific Islander □ White □ Other Race
□ Unknown □ Declined

**Ethnicity** (Choose one)

□ Hispanic or Latino □ Non Hispanic or Latino □ Declined to Report

**Preferred Language** (Choose one)

□ English □ Spanish □ French □ Chinese □ Other

**Preferred Pharmacy**: _____________________________ Location: _______________________________

**Father's Name** ________________________________________________________

Date of Birth___________________________ SS # ______________________________

Home #_____________________ Work # ______________________ Cell # ______________________

Address (If different from child's) ____________________________________________

____________________________________________

**Mother's Name** _______________________________________________________

Date of Birth___________________________ SS # ______________________________

Home #_____________________ Work # ______________________ Cell # ______________________

Address (If different from child's) ____________________________________________

____________________________________________

**Email Address** ________________________________________________ (To receive OHPA correspondence)

*__THIS SECTION IS FOR NEWBORNS ONLY:__*

Is patient being added to father's insurance? Yes _______ No _______
**If yes:** Insurance Company: ____________________________Plan Name ______________________________
Patient ID: ____________________________ Group Number: _________________________________

____________________________________________

Is patient being added to mother's insurance? Yes ________No _______
**If yes:** Insurance Company: ____________________________Plan Name _______________________________
Patient ID: ____________________________ Group Number: _________________________________

Have you applied for a TennCare plan for your child? Yes _______ No ________