AACPP FOSTER CARE AGENCY REGISTRATION

Account #: *Date Completed:* 4/2011

Patient Name:		*Birthdate:*
SSN:	*M / F:*	*Current School:*

A. GUARDIAN/FOSTER PARENT INFORMATION

1. Name:		*2. Birthdate:*
3. Address:		
4. Home Phone:	*5. Cell Phone:*	*6. Work Phone:*
7. Email:		

B. FOSTER CARE AGENCY INFORMATION

1. Agency Name:	
2. Address:	
3. Caseworker Name:	
4. Phone #:	*5. Email:*

C. INSURANCE INFORMATION

1. Primary Insurance Company:	
2. Policy Holder Name:	*3. Birthdate:*
4. Policy Number:	*5. Group Number:*
6. Insurance Phone Number:	
7. Secondary Insurance Company:	
8. Policy Holder Name:	*9. Birthdate:*
10. Policy Number:	*11. Group Number:*
12. Insurance Phone Number:	
13. ACCESS (PA Medicaid Number):	
We will need to see a copy of your child's insurance card at every visit.	

C. HISTORY

1. Prior School:	*2. County:*
3. List other agencies involved:	*4. Contact Name/Phone:*
5. Prior Primary Doctor:	*6. Phone:*
7. List any specialists involved:	*8. Phone:*
9. Allergies:	

10. Medications:	*Prescribing Doctor/Phone #:*	*11. Pharmacy where last filled/Phone #:*
12. Durable Medical Equipment Needs (ie - nebulizer, wheelchair, g-tube, etc)		*13. Supplier Name/Phone Number:*

D. CURRENT CONCERNS/SOCIAL HISTORY

1. Urgent concerns:
2. Name, ages & custody arrangements of siblings:
3. Reason for foster placement:

E. Please provide us with specific information and legal documentation as to who can schedule/cancel appointments, who we are allowed to speak with regarding this patient, who may come to appointments with the child, and any other relevant custody information:

We must have an immunization record and a signed release to obtain information from previous medical providers before we can schedule an appointment for any patient.

(Please use the back for additional information)