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NEW PEDIATRIC PATIENT INFORMATION

Date: _____

(Please list ALL children in the family that are patients at this practice ages 18 and under.)

	Child 1	Child 2
Last Name	_____	_____
First Name	_____	_____
Middle	_____	_____
DOB	_____	_____
Nickname	_____	_____
Preferred Language	_____	_____
Ethnicity	_____	_____

Preferred Pharmacy:
Name: _____
Address: _____
_____
Phone number: _____

Alternative Pahrmacy: _____

PARENTAL INFORMATION

MOTHER/LEGAL GUARDIAN
Name _____
DOB _____ SSN# _____
Mailing Address _____
City _____**State**_____ **Zip Code**_____
Cell Phone _____
Alternate Phone _____
Employer _____
Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language _____

☐ **Step Mother** [IF applicable]

FATHER/LEGAL GUARDIAN ☐**check if SAME address**
Name _____
DOB _____ SSN# _____
Mailing Address _____
City_____ **State**_____ **Zip Code**_____
Cell Phone _____
Alternate Phone _____
Employer _____
Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed
Preferred Language _____

☐**Step Father** [IF applicable]

Who do the children reside with? ☐ Father ☐ Mother ☐ Other _____

Who has legal custody of the child/children? ☐ Both ☐ Father ☐ Mother ☐ Other _____
Please provide any applicable legal documents.

Who is responsible for the medical bills? ☐ Father ☐ Mother ☐ Other _____
Which phone # should we list as your primary contact? _____ **Is it ok to leave a message at this #?** _____

What is your preferred method of communication? ☐ Phone _____ OK to leave a message? _____

☐ Email _____ OK to send email regarding billing/medical?_____

INSURANCE INFORMATION

PLEASE NOTE: YOU WILL BE ASKED TO PRESENT YOUR INSURANCE CARD AT **EVERY VISIT**

PRIMARY INSURANCE
Insurance Company _____
Member/Subscriber# _____
Group # _____
Issue/Effective Date _____
Employee's Name _____
Employee's DOB _____
Employer _____

SECONDARY INSURANCE
Insurance Company _____
Member/Subscriber # _____
Group # _____
Issue/Effective Date _____
Employee's Name _____
Employee's DOB _____
Employer _____

EMERGENCY CONTACT (Other than Parent)- If applicable

Name _____ Relationship _____
Cell Phone _____ Alternate Phone _____

SIGNATURE OF PARENT/GUARDIAN: _____ **Date:** _____

How did you hear about US? □ Yellow Pages online □ RTP Links □ Friend/Family/Neighbor □ Other Physician