Patient Information Form

Child's Information

Child's Name ____ □ Male □ Female

(First) (Middle) (Last)

Name Preferred ___________________________________Child's DOB _______________________

Child's Street Address ____

City ________________ State ________ Zip _________ Home # ______________________________

Child's Mailing Address____

City ________________ State ________ Zip _________ Home # ______________________________

Preferred Language _________________ Ethnicity □ Not Hispanic □ Latino

Race: __ Asian, __ Black/African American, __ White, __ Hispanic, __Other, ___________________

With whom does child live with? □ Mom and Dad □Mom □Dad □Other ________________

Who has legal custody? □ Mom and Dad □Mom □Dad □Other ________________

Who is responsible party? □ Mom and Dad □Mom □Dad □Other ________________

Preferred EMAIL for Patient Portal: ____

Preferred Method for Appointment Reminders: Email Call Text

Parent's or Legal Guardian's Information

Legal Guardian's Information

Relationship to patient: _______________

Name ______________________________

DOB _____________ SS#_____________

Address _____________________________

City_______________________________

State____________ Zip _______________

Home # __________Cell # _____________

Work # ______________________________

Email Address ______________________

Legal Guardian's Information

Relationship to patient: ________________

Name ______________________________

DOB _____________ SS#_______________

Address _____________________________

City_______________________________

State____________ Zip _______________

Home # __________Cell # _____________

Work # ______________________________

Email Address _______________________

Emergency Contact & Relationship to Patient (Someone not in home)

1. Name ________________________ Relationship _________________ Phone# ____________

2. Name ________________________ Relationship _________________ Phone# ____________

Do emergency contacts listed above have permission to be present and make medical decisions for patient i.e. receiving vaccines, diagnostic labs, etc. (Please ask office staff if any clarification is needed)?

1) □ Yes □ No 2) □ Yes □ No

Insurance Information

Primary Insurance Name: ____

ID Number: _______________________ Group Number: _________________________

Full Name of Insured: ______________________________ DOB:_________ SS#:________________

Secondary Insurance Name (If applicable) ____

ID Number: _______________________ Group Number: _________________________

Full Name of Insured: ______________________________ DOB:_________ SS#:________________

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that if my child’s account goes to a collection agency, I will be responsible for any cost incurred during the collection process, including collection fees, attorney fees and court fees.

Name: ___________________________________ Relationship to Patient ___________________

Signature: ________________________________ Date: ________________________________