PEDIATRIC CENTER

Patient Information Sheet
(Please Print)

PATIENT DATA

Child's Full Name _____ Sex: ❒ M ❒ F Date _____

Child's Home Address _____ Date of Birth _____ Age _____

_____ Zip _____ Home Phone _____

Name and Ages of Other Children seen by Pediatric Center? _____

How did you hear about Pediatric Center? _____

Have you arranged to have your child's medical records sent here from another doctor? _____

FAMILY DATA

Father's Name _____	Mother's Name _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
Work Phone _____	Work Phone _____
Mobile/Pager _____	Mobile/Pager _____
Driver's License # _____	Driver's License # _____

RESPONSIBLE PARTY IF NOT PARENT

Last Name _____	Sex: ❒ M ❒ F Relation to Patient _____
First Name _____ Initial _____	Date of Birth _____
Address _____	Social Security # _____
City, State, Zip _____	Home Phone _____
Employer _____	Work Phone _____

EMERGENCY CONTACT

Nearest Friend/Relative (Not Living With Parent)		Relation to Patient
Address (City, State, Zip)	Mobile/Pager No.	Phone No. Work No.

INSURANCE INFO

INSURANCE INFORMATION: PLEASE PROVIDE COPY OF INSURANCE CARD(S)

Primary Insurance _____	Secondary Insurance _____
Policy Owner/Subscriber _____ D.O.B. _____	Policy Owner/Subscriber _____ D.O.B. _____
Policy ID _____ Group # _____	Policy ID _____ Group # _____
Relation to Patient _____	Relation to Patient _____

Please be advised that we do not hold insurance companies responsible for payment. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. **Person responsible for payment is person bringing child in for treatment.**

Date _____ 20 _____ Signature _____

Account # _____ Patient # _____