Patient(s) Information

PLEASE COMPLETE ALL SECTIONS

*Please list ***ALL*** names of children we will be caring for

Last Name	First Name	M.I.	Sex	Date of Birth

***List in order of preferred contact**

Parent or Guardian Name:_____

Relationship to child(ren):_____Date of Birth:_____

Address:_____ City:_____ State:____ Zip:_____

Primary Phone: (___)_____ Secondary Phone: (___)_____

Email address:_____

Parent or Guardian Name:_____

Relationship to child(ren):_____Date of Birth:_____

Address:_____ City:_____ State:____ Zip:_____

Primary Phone: (___)_____ Secondary Phone: (___)_____

Email address:_____

HEALTH INSURANCE INFORMATION

Policy Holder:_____Social Security Number:_____

Occupation:_____ Employer's Name:_____

Name of Insurance Company:_____

Member ID:_____Group #:_____

Do you have SECONDARY INSURANCE coverage?: **YES** **NO**

Emergency contact other than parent:_____ Phone #: (___)_____

Preferred Pharmacy:_____ Phone #: (___)_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

As a convenience to our patients, we will submit all bills incurred by the above named child/children to your insurance company listed above. However, if reimbursement is not made within 90 days, you will be responsible for payment in full.

SIGNATURE_____ **DATE** _____