Established Patient Information

Child's Name_____ DOB_____

Child's SS#_____ MALE FEMALE

Name of child's female guardian_____

SS#_____DOB_____

Address_____

City_____ State_____ Zip Code_____

Home phone#_____ Alt phone#_____

Relationship to child: Biological Foster Adoptive Step Other_____

Name of child's male guardian_____

SS#_____DOB_____

Address if different_____

City_____State_____Zip code_____

Home phone#_____ Alt phone#_____

Relationship to child: Biological Foster Adoptive Step Other_____

Primary insurance provider_____

Name of insured_____

Member ID#_____Group#_____

If on Medicaid is child an SSI recipient? YES NO

Child's Primary Care Provider Information:

Doctor's name_____

Address_____

City_____State_____Zip code_____

Phone#_____ Fax#_____

Name of person filling out form_____ Today's date_____