PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

DOB:_____ SSN:_____ Male:_____ Female:_____

Race:_____ Ethnicity:_____

Who does child live with?:_____ Primary Language:_____

Parent/Guardian Information

Father: Last Name:_____ First Name:_____

DOB:_____ SSN:_____

Address:_____

City, State, Zip:_____

Primary Phone:_(____)_____ Alt Phone:_(____)_____

Mother: Last Name: _____ First Name: _____

Address:_____

City, State, Zip:_____

Primary Phone:_(____)_____ Alt Phone:_(____)_____

Emergency Contact not living with patient:_____ Phone:_(____)_____

Referring Doctor

Last Name:_____ First Name:_____ Clinical Name:_____

Primary Care Doctor

Last Name:_____ First Name:_____ Clinical Name:_____

Patient/Legal Guardian Signature:_____

Patient/Legal Guardian Printed Name:_____ **Date:**_____

Relation to patient:_____

Primary Insurance

Insurance Company:_____

Subscriber Name:_____ DOB:_____

Relationship to patient:_____ Phone number:_(____)_____

Policy ID#:_____ Group#:_____

Secondary Insurance ☐ **I do not have secondary insurance**

Insurance Company:_____

Subscriber Name:_____ DOB:_____

Relationship to patient:_____ Phone number:_(____)_____

Policy ID#:_____ Group#:_____