Children's Clinic P.A.

PATIENT INFORMATION FORM (18 YEARS OR OLDER)

Please fill out this form entirely.

PATIENT INFORMATION

First Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip Code: _____ Work Phone: _____

Employer Name: _____ Email Address: _____

Best number to Confirm Appointments: _____

Reminder Call Preference: ☐ Automated Voice ☐ Text

Race: ☐ White ☐ Black ☐ Asian Native ☐ American ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

PARENT/ EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____

Address: _____

City/State/ Zip: _____ Relationship_____

Name: _____ Phone Number: _____

Address: _____

City/State/ Zip: _____ Relationship_____

INSURANCE INFORMATION:

Primary Insurance:

Insurance: _____ Policy ID: _____ Group ID: _____

Policy Holder: _____ Date of Birth _____Relationship _____

Secondary Insurance:

Insurance: _____ Policy ID: _____ Group ID: _____

Policy Holder: _____ Date of Birth _____ Relationship _____

Guarantor (Person to be billed)

Name: _____ Relationship _____

Birthdate: _____ Phone Number_____

Address (If different from patient): _____

City: _____ State: _____ Zip: _____

Signature_____ Date _____

DATE: _____

OFFICE: _____