Children's Clinic P.A.

PATIENT INFORMATION FORM

Please fill out this form entirely.

MOTHER / FATHER/ GUARDIAN Information

Mother/ Father/ Guardian Information (for child(ren) listed below)

Name: _____ Date of Birth: _____
Mailing Address: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip Code: _____ Work Phone: _____
Employer Name: _____ Email Address: _____
Relationship: _____

Mother/ Father/ Guardian Information (for child(ren) listed below)

Name: _____ Date of Birth: _____
Mailing Address: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip Code: _____ Work Phone: _____
Employer Name: _____ Email Address: _____
Relationship: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

If Divorced: ☐ Joint Custody ☐ Sole Custody ☐ Legal Documents Provided

PATIENT INFORMATION

(Please List ALL Children Under 18)

Patient Legal Name	**Sex** M/F	**DOB** mm/dd/yy	**Child lives with?** Mother/Father/Both

Address child lives at *(If Other Than Above)*

Address _____ Phone_____
City_____State_____Zip_____

Reminder Call Preference: ☐ Automated Voice ☐ Text Preferred Number: _____

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: _____

Emergency Contact (Other Than Parent)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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: _____