Information Form for Pediatric Patients

Patient Information

Name: ______________________ Date of Birth: ______________

Address: ______________________

City: ______________________ State: _______ Zip Code: ______________

Parent/Guardian Information

Parent/Guardian's Name: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Parent/Guardian's Name: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Primary Insurance Information

Insurance Company: ______________________ Phone Number: ______________

Contract/Policy Number: ______________________ Group Number: ______________

Policy Holder's Name: ______________________ Relationship to Patient: ______________

Policy Holder's Employer: ______________________ Policy Holder's Date of Birth: ______________

Prescription coverage?: _____ Covered by insurance listed above ____Separate Prescription Card ___ No Prescription Coverage

Secondary Insurance Information

Insurance Company: ______________________ Phone Number: ______________

Contract/Policy Number: ______________________ Group Number: ______________

Policy Holder's Name: ______________________ Relationship to Patient: ______________

Policy Holder's Employer: ______________________ Policy Holder's Date of Birth: ______________

Prescription coverage?: _____ Covered by insurance listed above ____Separate Prescription Card ___ No Prescription Coverage

Additional Insurance Information

If your child has coverage through Medicaid or Children's Special Health Care Services, please list ID #:______________

Parent/Guardian Signature: ______________________ **Date**: ______________

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