Children's Medical Group, P.A.

PATIENT INFORMATION

Date: _____ Date of Birth: _____

Patient's Name: _____ M ___ F ___

Email address for patient portal: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Primary Cell Number: (_____) _____ circle one: mom dad other

Alternate Number: (_____) _____ type: home cell

Mother's name: _____ Date of Birth: _____

Employer: _____ Work Phone: (_____) _____

Father's name: _____ Date of Birth: _____

Employer: _____ Work Phone: (_____) _____

WE MUST HAVE A COPY OF THE INSURANCE CARD AND PICTURE ID TO OBTAIN INFORMATION AND FILE CLAIMS AT THE TIME OF EACH VISIT.

Primary Insurance: _____

Subscriber's Name: _____

Relationship to patient: _____

Employer: _____ Group # _____

Secondary Insurance: _____

Person responsible for this bill: _____

Address of billing if different from patient's: _____

City: _____ State: _____ Zip: _____

Name of Siblings:	Date of Birth:	Name of Siblings:	Date of Birth:
_____	_____	_____	_____
_____	_____	_____	_____

The following individuals have my permission to bring my child for treatment:

_____

_____

Emergency Contact: Name _____ Phone # (_____) _____

Mailing address: _____ Relationship _____