Patient Information

Patient/Child: _____ DOB: _____

Patient Nickname/Preferred Name:_____ Age: _____ Gender:_____

SS#:_____ School: _____

Home Address:_____ Different mailing address?_____

City/State: _____ Zip: _____ County:_____

Who referred you/how did you hear about us? _____

Communications: * Circle preferred/best phone number for us to call you. *

Home: _____ Work: _____ Cell/text:_____

Email(s): _____

Emergency contacts, other than legal parents/guardians (For emergencies, loss of contact only):

1) _____ Phone(s): _____

2) _____ Phone(s):_____

Legal Parent/guardian Information: Birth parent and/or must have legal custody/guardianship

Parent 1: Circle: Mother/Father Step-Mother/Father Legal guardian Other:_____

Name: _____ DOB: _____ SS#: _____

Driver's License #: _____ State of Issue: _____

Address if different from child:_____

Parent 2: Circle: Mother/Father Step-Mother/Father Legal guardian Other:_____

Name: _____ DOB: _____ SS#: _____

Driver's License #: _____ State of Issue: _____

Address if different from child :_____

Primary Insurance Information

Subscriber: _____ Relationship:_____

Subscriber SS#: _____ Subscriber DOB: _____

Employer: _____ Employer city, state: _____

Insurance: _____ Payor ID:_____

Group #:_____ Phone: _____

Claims Address: _____ City/State: _____ Zip: _____

Secondary Insurance Information

Subscriber: _____ Relationship:_____

Subscriber SS#: _____ Subscriber DOB: _____

Employer: _____ Employer city, state: _____

Insurance: _____ Payor ID:_____

Group #:_____ Phone: _____

Claims Address: _____ City/State: _____ Zip: _____