

Patient/Insurance Information

(Please print and complete all sections)

Children's Legal Names as they will appear on the insurance card.

1. _____ DOB _____ M/F

4. _____ DOB _____ M/ F

2. _____ DOB _____ M/F

5. _____ DOB _____ M/ F

3. _____ DOB _____ M/F

6. _____ DOB _____ M/ F

Parents Information

<i>Mother's Information</i>	<i>Father's Information</i>
Name: _____	Name: _____
DOB: _____	DOB: _____
Primary Phone #: _____ Work/Home/Cell	Primary Phone #: _____ Work/Home/Cell
Secondary Phone #: _____ Work/Home/Cell	Secondary Phone #: _____ Work/Home/Cell
Preferred daytime contact? Please circle one: Work/Home/Cell	Preferred daytime contact? Please circle one: Work/Home/Cell
Address: _____	Address: _____
City _____ State _____	City _____ State _____
Zip _____ E-mail _____	Zip _____ E-mail _____

With whom does the child live with?	Mom and Dad together _____	Mom _____	Dad _____	Other _____
Who has legal custody?	Mom and Dad together _____	Mom _____	Dad _____	Other _____

Insurance Information

Is there a court order/divorce decree dictating who is responsible for primary health coverage? Yes ___ No ___

Primary Insurance Information

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SS# _____

Primary Insurance Company: _____ Customer Service Phone # _____

Insurance Address _____

Policy Number: _____ Group Number: _____

Employer's Name: _____ Employer's Phone # _____

Secondary Insurance Information

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SS# _____

Primary Insurance Company: _____ Customer Service Phone # _____

Insurance Address _____

Policy Number: _____ Group Number: _____

Employer's Name: _____ Employer's Phone # _____

Please sign and date:

Guarantor/Responsible Guardian _____ Relationship to Patient _____

Date _____