Patient Demographics- PLEASE FILL OUT COMPLETELY

Name of Patient _____
Last name First Middle

Address _____
Street

_____
City State Zip Code

Patient's Date of Birth _____ Home Phone ( ) _____
Month Day Year

Patient's Gender: Male Female How did you hear about us? Phonebook / Internet / Friend / Radio/ Other _____

Please circle one of the following:

Race: White / Black / American Indian / Asian / Pacific Islander / Other

Please circle one of the following:

Ethnicity: Hispanic/Latino or NON-hispanic/latino

E-mail address: _____

Best method of contact: cell phone / home phone

Mother's Name _____
(Or Guardian) Last name First Middle Maiden (REQUIRED)

Mother's Date of Birth _____
(Or Guardian)
Mother's Home Phone ( ) _____

Mother's Social Security Number _____
(Or Guardian)
Mother's Cell Phone Number ( ) _____

Mother's Home Address _____

Father's Name _____
(Or Guardian) Last name First Middle

Father's Date of Birth
(Or Guardian) _____
Father's Home Phone ( ) _____

Father's Social Security Number
(Or Guardian) _____
Father's Cell Phone Number ( ) _____

Father's Home Address _____

Insurance Information

Primary insurance company name
Policy Holder name _____ Date of Birth _____
Address of Policy Holder (if different from above) _____
Policy Holder Employer _____ Policy Holder SSN # _____
Relationship of Patient to Policy Holder _____

Secondary insurance company name
Policy Holder name _____ Date of Birth _____
Address of Policy Holder _____
Policy Holder Employer _____ Policy Holder SSN # _____
Relationship of Patient to Policy Holder _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFIT TO PREMIERE PEDIATRICS

I authorize the release of any medical or other information necessary to process this claim. I authorize the provider to release information required in the course of my examination and treatment. I also authorize payment of any government benefits (if applicable) to Premiere Pediatrics. I authorize payment of medical benefits to the physician for services rendered. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signature _____ Date _____
Parent or Guardian (if patient is a minor)