

REG _____

Peninsula Pediatric Patient Information

C NP

Today's Date _____ Child's Physician: _____ Referred By: _____

Sex: M () F ()

Child's Last Name _____ Child's First Name _____ MI _____

Date of Birth _____ Child's Social Security # _____ Child Resides with _____

Mother's Full Name _____ Date of Birth _____ Social Security # _____

Mother's Street Address _____ City _____ State _____ Zip Code _____

Mother's Employer _____ Mother's Occupation _____

Mother's Home # _____ Cell Phone # _____ Work Phone # _____

Father's Full Name _____ Date of Birth _____ Social Security # _____

Father's Street Address _____ City _____ State _____ Zip Code _____

Father's Employer _____ Father's Occupation _____

Father's Home # _____ Cell Phone # _____ Work Phone # _____

List All Siblings Names with Birthdates _____

INSURANCE INFORMATION

PLEASE PROVIDE INSURANCE CARD

PRIMARY INSURANCE NAME: _____ Effective Date _____

ID # _____ Group # _____

Subscriber Name _____ Patients Relationship to Subscriber _____

SECONDARY INSURANCE NAME: _____ Effective Date _____

ID # _____ Group # _____

Subscriber Name _____ Patients Relationship to Subscriber _____

If Parent Cannot Be Reached Please Call _____ Phone # _____

Relationship to Child _____

STATEMENT OF RESPONSIBILITY

I have given this office my correct and current insurance information. I agree that it is solely my responsibility to notify the office of current insurance, address and telephone numbers. Should the information provided be incorrect I agree to be responsible for any and all amounts billed to me. I also understand and agree that I am responsible for all co-payments, deductibles and amounts for services that my insurance plan does not cover, including out of plan services. In signing this document I give this office permission to release my medical record to my Insurance Company upon their request.

Parent or Legal Guardian Signature _____

Please Print Name _____