

WELCOME TO INFANTS AND CHILDREN, P.A.

In order to serve you properly, we will need the following information:

PATIENT INFORMATION

Account#: _____ **Date:** _____

Name: _____ **Sex** Male Female

Date of Birth: _____ **Age:** _____ **Child's S.S#:** _____

Address: _____ **City/State/Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Primary Language Spoken at Home: _____

Previous Records May Be Obtained from: _____

Other Siblings (Name & Ages): _____

Email Address: _____

Whom May we thank for referring you to us? _____

INSURANCE INFORMATION (Please give insurance card(s) to receptionist to photocopy upon arrival)

Do you have medical insurance? Yes No **Insurance Co. Name:** _____

Do you have Medicaid and/or are you applying for Medicaid? Yes No

Insurance Subscriber – Name, Date of Birth, and Social Security Number _____

IN CASE OF EMERGENCY (Not living with you)

Name: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

PARENT INFORMATION

Mother's Name: _____ **Father's Name** _____

SS#: _____ **SS#:** _____

Date of Birth: _____ **Date of Birth:** _____

Address: _____ **Address:** _____

City/State/Zip: _____ **City/State/Zip:** _____

Home Phone: _____ **Home Phone:** _____

Cell Phone: _____ **Cell Phone:** _____

Employer: _____ **Employer:** _____

Employer's Phone#: _____ **Employer's Phone#:** _____

City/State/Country where children were born: _____

Did one of our Physicians see your child(ren)? Yes No **Which One?** _____