



# THE CENTER FOR PEDIATRIC & ADOLESCENT MEDICINE

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## ABOUT YOUR CHILD

Today's Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Child's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Child's Home Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Nickname \_\_\_\_\_  Male  Female School \_\_\_\_\_ Grade \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
Street City State Zip

## PARENT'S INFORMATION

Parent's Marital Status:  Married  Divorced  Separated  Widowed  Remarried  Single

**Mother:**  Step Mother  Guardian Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security #: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Employer: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Father:**  Step Father  Guardian Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate : \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security # : \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**INSURANCE INFORMATION**

**Primary Insurance Co. :** \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance. Co:** \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

**WHO IS ACCOMPANYING THE CHILD TODAY?**

Name \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child?  Yes  No Is the child adopted  Yes  No

Is the child in a foster home?  Yes  No

Whom may we Thank for referring you? \_\_\_\_\_

**Nearest Relative Not Living With You**

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Payment is expected at the time of visit. **We DO NOT CHARGE** office visits. Emergency room visits, newborn hospital care, and hospitalizations are the **ONLY** charges allowed. **All managed care Co Pays must be paid at the time of visit.** Co Pays are required for every Regular office visit, Recheck office visit, for shots only visit, or lab only visits. When Insurance has paid the charge, the remaining balance is DUE and payable by you within 30 days. I hereby give Center for Pediatric and Adolescent Medicine and its physician’s permission to file for and receive payment for any Emergency Room, Newborn, Hospitalization, and Office Visit Charges. If you call for an appointment and are told it will be a **WORK-IN**, we will work you in as soon as we can. Scheduled appointments will come first! **WALK-INS** are **NOT** acceptable. Please do not do this.

**PLEASE NO FOOD OR DRINK ALLOWED IN THIS OFFICE**

**If you feel your child must have food or drink, please go outside. Small infants with bottles and non-spillable sippy cups are the only exceptions.**

SIGNATURE: \_\_\_\_\_