



Account # \_\_\_\_\_  
Reviewed by \_\_\_\_\_

Date \_\_\_\_\_

**Parent/Legal Guardian Information**

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address: \_\_\_\_\_

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

Email \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address: \_\_\_\_\_

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

Email \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Patient Information**

_____	_____	_____	Date of Birth _____	M / F
Last name	First name	middle initial		
_____	_____	_____	Date of Birth _____	M / F
Last name	First name	middle initial		
_____	_____	_____	Date of Birth _____	M / F
Last name	First name	middle initial		
_____	_____	_____	Date of Birth _____	M / F
Last name	First name	middle initial		

Patients live with  both parents  mom  dad  other (explain) \_\_\_\_\_

**Insurance Information**

Do you have insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, you will be expected to pay for today's visit at check-out.)

Primary Insurance Company \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder's Address (if different from above) \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

SIGNATURE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_

I AUTHORIZE CRESTWOOD PEDIATRIC TO BILL MY HEALTH INSURANCE AS PROVIDED ABOVE. I ACKNOWLEDGE THAT PAYMENT OF COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.