Date ____________

Reviewed by ________

Parent/Legal Guardian Information

Father's Name ______________________ Date of Birth ____________ SSN ____________

Address: ____

Phone ____________ ____________ ____________

Cell Work Email

Employer ____________ Occupation ____________

Mother's Name ______________________ Date of Birth ____________ SSN ____________

Address: ____

Phone ____________ ____________ ____________

Cell Work Email

Employer ____________ Occupation ____________

Patient Information- Please list all children 17 years old or younger

______________________________________ 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) ____________

Preferred Pharmacy: ______________________________________

(If your child is prescribed medication)

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

____________ ____________ ____________

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.