Ashe Pediatrics Patient Portal

INTELICHART®
Engagement to Outcomes

Child's Name: Last_____ First_____ Middle _____

Date of Birth: _____ Male / Female Social Security # _____-_____-_____

Physical Address (street): _____

Physical Address (city, state, zip): _____

Mailing address (if different-PO Box): _____

Mailing address (city, state, zip): _____

Parent/guardian: Last_____ First_____

Date of Birth: _____ Male / Female Soc. Sec. # _____-_____-_____ D/L_____ State_____

Home Phone: _____ Daytime #: _____ Cell #: _____

Employer: _____ Relationship to child (circle): Parent / Guardian / Other_____

Child lives with: Mother / Father / Both Parents / Guardian / Other (specify) _____

Emergency Contact: _____ Relationship: _____

Daytime Phone #: _____ Cell Phone #: _____

Insurance Info: Medicaid / Health Choice / BCBS / United / Cigna / Aetna / Other (specify)_____

Policy holder's name: _____ Policy holder DOB_____

SS#_____-_____-_____ Policy #_____ Group #_____

****What email address would you like to use for our new Patient Portal:**

_____

_____ _____ _____

Parent/Guardian Signature Printed Name Date

Office use only: **Patient Pin sent: Yes No** **Initials:** _____