Pediatric Neurology of Lehigh Valley
Boosara Ratanawongsa, M.D
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 610.398.9899

DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

Name:____ Today's Date: ____
Last First M

Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W

GENDER: □MALE □FEMALE

SSN: ____DOB: ____

RACE: □African American/Black □White □American Indian/Alaska Native □Asian □Native Hawaiian or Pacific Islander □ Declined

ETHNICITY: □Hispanic □Non-Hispanic □Declined

PARENT #1 INFORMATION

Name:____ SSN: ___________________________DOB: _________________________
Last First M
Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W E-mail________________________________

Occupation: ____Employer____

Relationship with patient__________________________ Do you live with child? □NO □YES

PARENT #2 INFORMATION

Name:____ SSN: ___________________________DOB: _________________________
Last First M
Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W E-mail________________________________

Occupation: _________________________________ Employer____

Relationship with patient__________________________ Do you live with child? □NO □YES

EMERGENCY CONTACT #1

Name:____Relationship____

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W

EMERGENCY CONTACT #2

Name:____Relationship____

PHONE #1(______)_______-________ □ H□C□W PHONE #2(______)_______-________ □ H□C□W

REFERRAL INFORMATION

Referring physician name: ____ Phone:(____)______-_______ Fax:(____)_______-________

Address:____

Street Address City State Zip Code

PRIMARY CARE PHYSICIAN INFORMATION

PCP name: ____ Phone:(____)______-_______ Fax:(____)_______-________

Address:____

Street Address City State Zip Code

INSURANCE INFORMATION

____

PRIMARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER NAME____RELATIONSHIP____

____

SUBSCRIBER SSN DOB EMPLOYER WORK #

DO YOU HAVE A SECONDARY INSURANCE? □ NO □ YES. IF SO, PROVIDE INFORMATION BELOW

____

SECONDARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER
NAME____RELATIONSHIP____

____

SUBSCRIBER SSN DOB EMPLOYER WORK #

PHARMACY INFORMATION

PREFERRED PHARMACY NAME____

ADDRESS____

PHONE (__________)_________-__________ FAX NUMBER (__________) _________-___________

The information I provided is correct to the best of my knowledge.

Parent/Guardian Signature______________________________________Date____