CARING HANDS PEDIATRICS

Patient's Name:_____ **Male / Female**

Date of Birth: / / Race:_____ **Language:**_____ **Hispanic origin:** **Yes** **No**

Address: _____ **City:** _____

State/Zip Code: _____ **Home Phone:** _____

Father/Guardian Name: _____ **Birth father** **Yes** **No**

Father cell phone: _____ **Preferred method of contact: (circle only one)**

Fathers email address:_____ **Home Cell Email**

Mother/Guardian Name: _____ **Birth mother** **Yes** **No**

Mother cell phone: _____ **Preferred method of contact: (circle only one)**

Mothers email address:_____ **Home Cell Email**

FINANCIALLY RESPONSIBLE PARTY

(If different from above)

Responsible Party's Name: _____

Responsible Party's Address: _____

PLEASE PRESENT INSURANCE CARD(S) FOR SCANNING AND COMPLETE ALL REQUESTED INFORMATION BELOW

Insurance Company #1: _____**Social Security Number:** _____

Primary Card Holder Name: _____**Date of Birth:**_____

Policy# _____**Group #** _____**Relationship:** _____

Insurance Company #2:_____**Social Security Number:**_____

Primary Card Holder Name: _____**Date of Birth:**_____

Policy# _____**Group #** _____**Relationship:** _____

Please share with us how you where referred to our office: _____

AUTHORIZATION FOR CARE

We believe that it is best for you child to be with a parent or legal guardian at every office visit. However, we realize that this is not always possible. We would like to know who has your permission to present your child for medical care.

First and last name: _____**Relationship to patient:** _____

First and last name: _____**Relationship to patient:** _____

PARENT/GUARDIAN SIGNATUE:_____ **DATE: / /**