CHILDREN'S MEDICAL CENTER
Patient Information Sheet

PATIENT NAME: _____ Nickname: _____
Last First Middle

DOB:_____ Sex: ☐ Female ☐ Male Cell Number if teenager:_____

Race: (Please Choose One): ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American
☐ More than one race ☐ Native Hawaiian/other Pacific Islander ☐ Other ☐ White ☐ Declined to answer

Ethnicity: (Please Choose One): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Answer

Primary Care Physician ☐ Markson ☐ Lashlee ☐ Zavadil ☐ Papadopoulos ☐ Taylor ☐ Porter ☐ Ambardekar

(Please list all siblings on the back of this form)

FATHER OF CHILD:

Name: _____
Last First MI

Date of Birth: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number:_____

Best Number to Call: ☐ Home ☐ Cell ☐ Work

MOTHER OF CHILD:

Name: _____
Last First MI

Date of Birth: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Best Number to Call: ☐ Home ☐ Cell ☐ Work

Emergency Contact: _____ Relationship:_____Phone #:_____

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Other Child (ren) live(s) with ☐ Mom ☐ Dad ☐ Other

Written Language of Family: _____ Spoken Language of Family:_____

Insurance: _____ Insured's Name: _____

Insurance ID Number: _____ Group Number: _____

Employer: _____ Occupation: _____

Sibling's NAME: ____ Nickname: _________________________
Last First Middle

DOB:_______________ Sex: ☐ Female ☐ Male Cell Number if teenager:______________________________

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I have received a copy of the HIPPA agreement, and understand that personal information will be obtained to assist in accurate billing and collection. I understand that my insurance policy is a contract between the insurance company and myself and that Children's Medical Center is not a party to that contract. I am aware that some or all of the services provided may be non-covered services for which I may also be billed. I authorize payment of medical benefits to physicians or suppliers of these services and all future claims. I also authorize the release of any medical information necessary to process this and all future claims.

Signature: ____ Date: __________________________