CHILDREN'S MEDICAL CENTER Patient Information Sheet

| PATIENT NAME: | | Nickname: | | | | | | | |
|--|---------------|--|-----------------|---|--------------|----------------|-----------------|-------------|--|
| | Last | First | Middle | | | | | _ | |
| DOB: | | Sex: () Female () Mal | e Cell Num | nber if teena | ager: | | | | |
| Race: (Please Circle Pacific Islander, Ot | - | rican Indian/Alaska Native Declined to answer | e, Asian, Blacl | k/African Am | erican, More | than one ra | ce, Native Hawa | aiian/other | |
| Ethnicity: (Please C | ircle One): H | lispanic or Latino, Not His | spanic or Latir | no, Declined | to Answer | | | | |
| PCP () Markson (|) Papadopou | ılos () Ambardekar () Cł | nen-Becker (|) Sweeney (|) Ginder()I | Mickey () Gil | lliland | | |
| PARENT/LEGAL G | | | | PARENT/LEGAL GUARDIAN 2: | | | | | |
| () mother () fath | | () mother () father () other | | | | | | | |
| | r | irst MI | | Name: | Last | | First | | |
| Last | | | | | | | | MI | |
| Date of Birth: | | | | Date of B | irtn: | | | | |
| Social Security Number: | | | | Social Security Number: | | | | | |
| Home Address: | | | - | Home Address: | | | | | |
| City: | State | :Zip: | - | City: | | State: | Zip: | | |
| Home Phone Nur | nber: | | | Home Ph | one Numbe | er: | | - | |
| Cell Phone Number: | | | | Cell Phone Number: | | | | | |
| Work Phone Number: | | | | Work Phone Number: | | | | | |
| Best Number to Call: Home / Cell / Work | | | | Best Number to Call: Home / Cell / Work | | | | | |
| Email: | | | | Email: | | | | | |
| Employer: | | | | Employer: | | | | | |
| Occupation: | | | | Occupatio | n: | | | | |
| Emergency Conta | act: | | Relationshi | ip: | Phone # | : | | | |
| Parents are: () M | larried () D | vivorced () Separated (| () Other | Child (ren) | live(s) with | | | | |
| Written Language | of Family: | | Spoken Lang | uage of Fami | ly: | | | _ | |
| Insurance: | | | | Insured's | Name: | | | | |
| Insurance ID Number: | | | | Group Number: | | | | | |

| Sibling's NAME: | | | () full sibling () ½ sibling () step sibling () other |
|--|---|----------------------|---|
| Last | First | Middle | |
| DOB: | _ Sex: () Female () Male | Cell Number i | f teenager: |
| Race: (Please Circle One): Pacific Islander, Other, W | | ive, Asian, Black/ | African American, More than one race, Native Hawaiian/other |
| Ethnicity: (Please Circle C | ne): Hispanic or Latino, Not H | lispanic or Latino | , Declined to Answer |
| PCP () Markson () | Papadopoulos () Ambardo | ekar () Chen-I | Becker () Sweeney () Ginder () Mickey () Gilliland |
| Sibling's NAME: | | | () full sibling () ½ sibling () step sibling () other |
| Last | First | Middle | |
| DOB: | _ Sex: () Female () Male | Cell Number i | f teenager: |
| Race: (Please Circle One): Pacific Islander, Other, W | | ive, Asian, Black/ | African American, More than one race, Native Hawaiian/other |
| Ethnicity: (Please Circle C | ne): Hispanic or Latino, Not H | lispanic or Latino | , Declined to Answer |
| PCP () Markson () | Papadopoulos () Ambard | ekar () Chen-I | Becker () Sweeney () Ginder () Mickey () Gilliland |
| | | | |
| Sibling's NAME: Last | First | Middle | () full sibling ()½ sibling () step sibling () other |
| DOB: | _ Sex: () Female () Male | Cell Number i | f teenager: |
| | American Indian/ Alaska Nat hite, Declined to answer | ive, Asian, Black/ | African American, More than one race, Native Hawaiian/other |
| Ethnicity: (Please Circle C | ne): Hispanic or Latino, Not H | lispanic or Latino | , Declined to Answer |
| PCP () Markson () | Papadopoulos () Ambard | ekar () Chen-l | Becker () Sweeney () Ginder () Mickey () Gilliland |
| L have received a conv of the | HIPPA agreement and understa | and that nersonal ir | formation will be obtained to assist in accurate hilling and collection |

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: |
|------------|-------|
| | |