CHILDREN'S MEDICAL CENTER
Patient Information Sheet

PATIENT NAME: _____ Nickname: __ _____
Last First Middle

DOB: _____ Sex: ( ) Female ( ) Male Cell Number if teenager: _____

Race: (Please Circle 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 Circle One): Hispanic or Latino, Not Hispanic or Latino, Declined to Answer

PCP ( ) Markson ( ) Zavadil ( ) Papadopoulos ( ) Ambardekar ( ) Chen-Becker ( ) Sweeney ( ) Ginder ( ) Mickey

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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

Email: _____

Employer: _____

Occupation: _____

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

Email: _____

Employer: _____

Occupation: _____

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: _____

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Family Medical History: _____

_____

_____

Sibling's NAME: _____ Nickname: _____
Last First Middle

DOB: _____ Sex: ( ) Female ( ) Male Cell Number if teenager: _____

Race: (Please Circle 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 Circle One): Hispanic or Latino, Not Hispanic or Latino, Declined to Answer

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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: _____