



Date: _____

Annual Verification/Date/Initials (Only initial and date ONCE per year)

Patient Information:

Please List All Children in the Family

If children do not share the same biological parents, please fill out separate forms

	First	Middle	Last	Birthdate	Gender	Race
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

Guarantor (Parent Responsible for Payment)

Other Parent

Full Legal Name _____
Male or Female (Circle One)

_____ _____
Male or Female (Circle One)

Parent SSN: _____

Birthdate: _____

Address: _____

City, State, Zip: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Occupation: _____

Person Child Lives With: _____

Emergency Contact: _____

Emergency Contact Phone: _____

*Parents are: ___ Single ___ Married ___ Separated ___ Divorced ___ Other

-If Single, Separated or Divorced, does non-custodial parent have the right to bring the child to the doctor? **YES or NO (Please Circle One)**

Please list anyone other than Parents/Guarantors who are allowed to bring your child to the office visit and whom you give permission to speak to the provider regarding your child's health. ******MUST BE 18 YEARS OR OLDER! ******

Name & Number _____ Relationship: _____

Name & Number: _____ Relationship: _____

Name & Number: _____ Relationship: _____

Name & Number: _____ Relationship: _____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Little Rock Children's Clinic, P.A. effective December 1st, 2015.

Signature _____ Printed Name _____ Date _____

INSURANCE INFORMATION

PRIMARY POLICY INFORMATION

Primary Insurance/ Plan Name:		Subscriber ID #/ Member ID #:		
Group #:		Subscriber First & Last Name:		
Subscriber DOB:	Sex of Subscriber:	Employer:		
Subscriber Address (if different from Account & Patient)		City:	State:	Zip:

SECONDARY POLICY INFORMATION

Primary Insurance/ Plan Name:		Subscriber ID #/ Member ID #:		
Group #:		Subscriber First & Last Name:		
Subscriber DOB:	Sex of Subscriber:	Employer:		
Subscriber Address: (if different from Account & Patient)		City:	State:	Zip:

NEWBORN

(Please select hospital of birth- circle below)

Baptist LR **Baptist NLR** **UAMS** **Other** _____