pediatric care corner

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Patient Intake Form

Patient

Last Name _____ First Name _____ M.I. _____

Date of Birth ____/____/____ Gender _____ Preferred Pronoun _____

Race _____ Ethnicity: ☐ Hispanic ☐ Middle Eastern ☐ Neither

Primary Address _____

City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____

E-Mail _____

Please list any siblings that are our patients _____

How were you referred to our office? _____

Parent 1: (Relationship to Patient _____)

Last Name _____ First Name _____

Parent 1's Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____

Employer _____ E-Mail: _____

Preferred method of contact: ☐ Email ☐ Text ☐ Call

Parent 2: (Relationship to Patient _____)

Last Name _____ First Name _____

Parent 2's Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____

Employer _____ E-Mail: _____

Preferred method of contact: ☐ Email ☐ Text ☐ Call

Emergency contact

Last Name _____ First Name _____

Primary Phone _____ Alternate Phone _____

Billing Information

Responsible Party

Last Name _____ First Name _____

Billing Address _____

City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____

Date of Birth _____ SSN _____

Relationship to Patient _____

Insurance information

Primary Insurance:

Insurance Name _____

Subscriber Name _____ Date of Birth ____/____/____

Subscriber ID _____ Group Number _____

Secondary Insurance:

Insurance Name _____

Subscriber Name _____ Date of Birth ____/____/____

Subscriber ID _____ Group Number _____

The Information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform Pediatric Care Corner, P.C. of any changes in my minor child's medical, insurance and or financial status. Additionally, I will inform Pediatric Care Corner, P.C. of any address changes that may affect billing. I certify that my minor child is covered by the above-named insurance company or companies, and I assign all insurance benefits to Pediatric Care Corner, P.C. I hereby authorize Pediatric Care Corner, P.C. and the doctors associated with the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

_____

Printed Name of Patient/ Guardian

_____ _____

Patient/ Guardian Signature Date