PATIENT INFORMATION FORM

Please write the name(s) of any other children currently being seen in this office:
_____

Please PRINT CLEARLY the following information:

Child's Last Name: _____First Name:_____

Child's Date of Birth: _____ Sex: Male ( ) Female ( )

Guarantor Parent's Last Name: _____First Name _____ MI _____

Parent's Date of Birth: _____Soc. Sec. Number _____ Sex M ( ) F ( )

Second Parent's Last Name: _____First Name_____

Parent's Date of Birth: _____Soc. Sec. Number _____Sex M ( ) F ( )

Phone Numbers: Home _____ Guarantor's Work Number _____

Cell _____Second Parent's Work Number _____

Address: _____

City, State, and Zip Code _____

Billing Address (if different) _____

Email Address _____

Primary Language Spoken at Home _____Ethnicity _____Race_____

Insurance Information (Please attach a copy of your child's insurance card)

Insurance Carrier Name _____

Subscriber's Name _____Subscriber's Date of Birth _____

Employer's Name and Address _____

Member # (if applicable) _____Group Number _____

Identification Number _____hild's Suffix _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance due on my account for all services rendered by Broad Ripple Pediatrics, including any late fees and/or service charges. I understand that all co-payments are due and payable at the time of the visit. I have read all the information on this form and have completed all the answers. I will notify you of any changes in my health insurance status or any of the above information.

Parent (Guardian) Signature _____Date _____