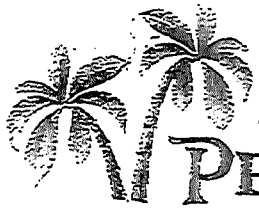

PATIENT INFORMATION

*Child's Name: _____ *DOB: _____ *Sex: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Language Preference: English Spanish Other_____

*Race: African American Asian Hispanic White Other____

*Ethnicity: Hispanic Non-Hispanic

Siblings and DOB seen here: _____

Biological/Legal
Parent Name_____

DOB_____

Address_____

City_____ State_____ Zip_____

Cell Phone#_____

Email_____

Employer_____

Occupation_____

Biological/Legal
Parent Name_____

DOB_____

Address_____

City_____ _State_____ Zip_

Cell Phone#_____

Email_____

Employer_____

Occupation_____

Step/Co-Parent Information

Name:_____DOB_____

Occupation:_____ Cell Phone#_____

Name:_____DOB_____

Occupation_____ Cell Phone#_____

Parent marital status_____ If single or divorced whom does child live with? _____

In case of an emergency, who should we contact? _____

Contact#_____ Relationship: _____

How did you find our office? _____

PATIENT INSURANCE INFORMATION

If you have Medicaid and **private insurance, BY LAW, Medicaid is always **secondary**. Medicaid **WILL** pay **ALL** fees the private insurance doesn't pay. There will be **NO** out of pocket expense.

***IT IS VERY IMPORTANT TO REPORT ALL INSURANCE COVERAGE TO US & YOUR INSURANCE COMPANIES. IF INSURANCE PAYS ON A CLAIM & LATER FINDS OUT THERE'S OTHER INSURANCE (EVEN IF IT'S SECONDARY) YOU WILL BE RESPONSIBLE FOR THOSE CHARGES. THIS HAPPENS ALL THE TIME & IT MAY BE YEARS LATER. AT THAT POINT IT'S TOO LATE TO FILE A CLAIM WITH THE CORRECT INSURANCE. THE INSURANCE WILL TAKE THE PAYMENT BACK, AND YOU WILL BE REPSONSIBLE FOR ALL CHARGES.

Primary Insurance Name: _____

Policy Holder: _____DOB: _____

Subscriber/ID_____ Group#_____

Relationship to patient: _____

Secondary Insurance Name: _____

Policy Holder: _____ DOB: _____

Subscriber/ID: _____Group#_____

Relationship to patient: _____

X_____ _____

Signature Date Signed

Printed Name_____