Pediatric Patient Intake Form

Patient Last Name: First Name: Gender: M F

Patient Address: City: \_\_\_\_\_\_\_\_\_ State: Zip:

Patient SS #: Patient Date of Birth:

Time of Birth: City of Birth:

Home #: ( ) \_ Cell #: ( ) Work #: ( )\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street: \_\_\_\_\_\_\_\_\_

Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_ State: Zip: \_\_

Home #: ( ) \_ Cell #: ( ) Work #: ( )\_\_\_\_\_\_\_\_\_\_

Parental Marital Status: Single: \_\_\_ Married: \_\_\_\_ Widowed: \_\_\_\_ Divorced: \_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Subscriber ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to the Patient: *self spouse dependent*

Date of Birth of Policy Holder: \_\_\_\_\_\_\_\_\_\_ SS# of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: City: \_\_\_\_\_\_ State: Zip: \_\_\_\_\_

Referred By: \_\_\_\_\_ Another Physician (Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Another Patient (Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Telephone Book \_\_ Home Pages \_\_\_ Website \_\_\_Insurance Co. \_\_ Other

I hereby authorize and consent to the giving of all treatments, examinations, medications and any technical procedures which in the judgement of the medical staff at Forefront Adult & Pediatric Care may be considered necessary or advisable for diagnosis or treatment. I also authorize Forefront Adult & Pediatric Care to release any information regarding my treatment required by my insurance company or third party payer for reimbursement of my treatment charges. I authorize payment directly to Forefront Adult & Pedatric Care for all benefits payable to me for this treatment. I understand that I am financially responsible to Forefront Adult & Pediatric Care for charges not covered or paid by my insurance carrier or third party.

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Insured (*If different than patient)*