PATIENT INFORMATION

Parent Name:_____

Relationship to child(ren)_____

Address:_____

City:_____

Zip:_____ County:_____

Employer:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Birthdate:_____

Parent Name:_____

Relationship to child(ren)_____

Address:_____

City:_____

Zip:_____ County:_____

Employer:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Birthdate:_____

Email Address:_____ Language Spoken in Home:_____

Name of Insurance 1:_____ Policy Holder:_____

Name of Insurance 2:_____ Policy Holder:_____

Do you have separate insurance coverage for pharmacy:_____ If yes, whom is it with:_____

With Whom Do Children Live?_____

Emergency Contact:_____ Phone:_____ Relationship:_____

PLEASE LIST ALL CHILDREN (PLUS CHILD BEING SEEN) THAT ARE PATIENTS IN THIS OFFICE + NEWPATIENT(S)

First Name	M.I.	Last	Birthdate	Sex	Race/Ethnicity	Present/Past Illness
1.						
2.						
3.						
4.						
5.						

Authorization to pay benefits to Physician:
I hereby authorize payment directly to Pediatric Care of Lansing, P.C. of benefits, if any, otherwise payable to me for their services. I recognize and accept personal responsibility for any balance or fee not covered.

Authorization to Release Information:
I hereby authorize Pediatric Care of Lansing, P.C. to release any information acquired in the course of my examination or treatment to my insurance company.

_____ Date:_____

PLEASE SIGN (PATIENT, PARENT OR LEGAL GUARDIAN)