North Pediatrics
PATIENT INFORMATION

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First	Middle:	Nickname:

How did you hear about us? (Circle one) Flyer Friend/Relative Facebook/Website Insurance Company Other______________________	Birth date:	Age:	Sex: Male Female

Responsible party for the account:	Relationship to the patient: _____

Street address:		Apt #
City	State	Zip
Mom's phone:	Father's phone	

PORTAL ACCESS: (you can view, shot records, labs, ask questions, schedule appointments and more)

Email Address:		Name:
Relationship to patient	Home phone	Mobile phone

Other Children living in the home:

	DOB:
	DOB:
	DOB:
	DOB:

Father's Legal Name		SS#
DOB:	Father's Employer	Work Phone:

Mothers Legal Name	Maiden Name:	SS#	DL#

DOB:	Mother's Employer	Work phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) * You must have a card to be seen.

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Insurance address:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Insurance Address:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature ______________________ Date ______________