

Date _____

PATIENT INFORMATION (Please Print)

Name _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone () _____ School _____ Grade _____

Referring Physician _____ Phone _____ Pharmacy _____

How did you hear about our clinic? Relative Friend Yellow Pages Newspaper Internet Radio Other

PARENT INFORMATION

Mother _____ Email Address _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Work () _____ Cell () _____

Occupation _____ Employer (company) _____

Father _____ Email Address _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Work () _____ Cell () _____

Occupation _____ Employer (company) _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier _____

Insured's Name _____ DOB _____ Relationship to Patient _____

Secondary Insurance Carrier _____

Insured's Name _____ DOB _____ Relationship to Patient _____

Emergency Contact if unable to reach you directly (Other than parents)

Name _____ Relation to Patient _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Work () _____ Cell () _____

I consent to treatment of myself/my child for routine medical care, including physical exam, well child care, and vaccinations. (I understand that I have the right to refuse treatment.)

I hereby authorize Community Pediatrics, SC to release to my insurance carrier any information including the diagnosis and record of any treatment or examination. I also authorize and request that Community Pediatrics, SC be paid directly for services rendered. I understand and agree that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient/Guardian _____ Date _____

Reason for Guardian Signature _____