The CHILDREN'S HEALTH PLACE

Office use only

Staff Initials: _____

Patient MRN : _____

Date : _____

NEW PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

First Name: _____ Last Name: _____

M.I: _____ Birth Date (MM/DD/YYYY): _____ Gender: ◯ Male ◯ Female

PARENT/GUARDIAN INFORMATION

#1 First Name: _____ Last Name: _____

Birth Date (MM/DD/YYYY): _____ SSN: _____

Email: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ ZIP _____

#2 First Name: _____ Last Name: _____

Birth Date (MM/DD/YYYY): _____ SSN: _____

Email: _____ Cell Phone: _____

Same address as above: ◯

Address: _____

City: _____ State: _____ ZIP _____

EMERGENCY CONTACT INFORMATION

Please list an individual other than a parent or guardian

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

SIBLING INFORMATION

Please list any siblings who will also become patients at The Children's Health Place

Name/DOB/Gender: _____

Name/DOB/Gender: _____

Name/DOB/Gender: _____

PARENT AUTHORIZATION

- *I hereby authorize payment of insurance benefits directly to The Children's Health Place. I understand that I am financially responsible for any charges not covered by my insurance policy.*
- *I hereby authorize The Children's Health Place to release any information acquired during my examination or treatment to my insurance company, referred healthcare provider or agency as required by law.*
- *I hereby give my consent for examination, diagnosis and/or treatment for my child*

_____ _____

Patient Signature Todays Date