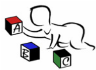

Premier Care Pediatrics

NEW PATIENT INFORMATION

PATIENT Today's Date ______/_____/______

Name: Last ________________________ First ________________________ Middle Initial ________

Address ____________________________________ City ________________________ State ______ Zip ___________

Home Phone (______) ______-_________ Cell Phone (______) ______-_________

Work Phone (______) ______-_________ Ext. ________

Permission to Leave Message Home ☐ Yes ☐ No Work ☐ Yes ☐ No

Current Pediatrician ________________________________ School ________________________________

Date of Birth _____/_____/_____ Sex ☐ F ☐ M Social Security # _________-_______-_______

Employer (if any) ______________________________ Address ______________________________________

PARENT/GUARDIAN

Relationship to Patient ________________________ Email ______________________________________

Name ______________________________________ Address ______________________________________

City ______________________________ State ________ Zip ___________ Home Phone (______) ______-_________

Cell Phone (______) ______-_________ Social Security # _______-_____-_______ Date of Birth _____/_____/_____

Employer ____________________________________ Address ______________________________________

City ___________________________ State _____ Zip ___________ Phone (______) ______-_________ Ext. _____

EMERGENCY CONTACT

Relationship to Patient ________________________

Name ______________________________________ Address ______________________________________

City ______________________________ State __________ Zip _____________

Home Phone (______) ______-_________ Work Phone (______) ______-_________ Ext. ________

AUTHORIZATION TO RELEASE INFORMATION TO:

Name ______________________________________ Relationship to Patient ____________________

Home Phone (______) ______-_________ Work Phone (______) ______-_________ Ext. ________

Address ____________________________________ City ________________________ State ______ Zip ___________

Name ______________________________________ Relationship to Patient ____________________

Home Phone (______) ______-_________ Work Phone (______) ______-_________ Ext. ________

Address ____________________________________ City ________________________ State ______ Zip ___________

Pharmacy ____________________________________ Address ______________________________________

Phone (______) ______-_________ Fax (______) ______-_________

Primary Insurance ________________________________ Policy Holder Name ________________________________

Policy Holder Sex ☐ F ☐ M Policy Holder DOB _______/_____/_______

Policy Holder SSN # _________-______-_________ Policy Holder Relationship to Patient ____________________

ID# ____ Group # ______________________________________

Secondary Insurance ______________________________ Policy Holder Name ________________________________

Policy Holder Sex ☐ F ☐ M Policy Holder DOB _______/_____/_______

Policy Holder SSN # _________-______-_________ Policy Holder Relationship to Patient ____________________

ID# ____ Group # ______________________________________

____ ____

Patient or Guardian Signature Relationship to Patient Date