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