**Patient (Child’s Info)**

|  |  |  |  |
| --- | --- | --- | --- |
| Name (Last, First) | Age | Birth Date | Gender |
| Mailing Address | City | State | Zip Code | Grade |

**Responsible Party (Parent Info)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name (Last, First) | Age | Birth Date | Gender | Relationship to Patient   |
| Address (put same if same as above) | City | State | Zip Code | Marital Status |
| Employer | Email | Cell Phone |
| How will you be paying? Please check  | \_\_ Credit Card \_\_ Check | \_\_ Insurance will cover all  |

**Referring Provider (Doctor)**

|  |  |  |
| --- | --- | --- |
| Name(Last, First) | Phone | Fax |
| Practice Name: |  |  |

**Primary Insurance Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Primary Insurance Company | Policy Holder Name | Date of Birth and SS# | Policy Number |  |
| Insurance Address | City | State | Zip Code | Group Number |  |
| Phone Number | Co-Insurance % | Co-Pay | Deductible |

 **Secondary Insurance Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Secondary Insurance Company | Policy Holder Name | Date of Birth | Policy Number |
| Insurance Address | City | State | Zip Code | Group Number |
| Phone Number | Co-Insurance % | Co-Pay | Deductible |

Signature of Insured or authorized person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_