**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_