

# Angel Kids Pediatrics Patient Information Sheet

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M  F   
Last First Middle

Patients SS# \_\_\_\_\_ Home email address \_\_\_\_\_

Home Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Child lives with: Mother  Father  Both

Mother's Name \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(IF DIFFERENT)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_

Father's Name \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(IF DIFFERENT)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

## EMERGENCY CONTACT

Name of friend /relative (not living at same address): \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

HOW DID YOU HEAR ABOUT ANGEL KIDS PEDIATRICS? \_\_\_\_\_

I certify that the above information is true and correct. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance that my insurance does not cover. I also authorize Angel Kids Pediatrics or my insurance company to release any information required to process my claims. I understand that there is a \$25 service charge for all returned checks.

Parent/Guardian Signature: \_\_\_\_\_ today's Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_