Welcome to The Children's Clinic!

NEW PATIENT INFORMATION

Child's Full Name: _____

(Please circle the name you wish us to use)

DOB: _____/_____/_____ Male □ Female □

Social Security # _____Birthplace/Hospital: _____

Primary Pharmacy: _____ City: _____

Pharmacy Phone # _____

Child lives with: □ Both Parents □ Mother □ Father □ Other _____

Primary Physician in our office: □ Dr. Denney □ Dr. Meador □ Dr. Smith
□ Dr. Cook □ Dr. Barron □ Dr. Adcock

Race
□ African American or Black
□ American Indian/Alaska Native
□ Asian
□ Caucasian/White
□ Native Hawaiian or Pacific Islander
□ Multi-Racial or Other
□ Unknown □ Declined

Ethnicity
□ Hispanic □ Not Hispanic
□ Declined □ Unknown

Please list all other siblings (seen at this clinic) you want on this account:

Child's Full Name: _____DOB:_____ Male □ Female □

Child's Full Name: _____DOB:_____ Male □ Female □

Child's Full Name: _____DOB:_____ Male □ Female □

Mother's Information □ **RESPONSIBLE FOR PAYMENT/GUARANTOR** ____ (initial)

Full Name: _____ DOB: ___/___/____ Social Security# _____

Mother's Maiden Name: _____ Employer: _____

Address: _____ City _____State_____Zip_____

Phone Numbers: Home_____Work _____Cell_____

(circle preferred primary contact number)

Father's Information □ **RESPONSIBLE FOR PAYMENT/GUARANTOR** ____ (initial)

Full Name: _____ DOB: ___/___/_____ Social Security # _____

Address: _____ City _____State_____Zip_____

Phone Numbers: Home_____Work _____Cell_____

(circle preferred primary contact number)

Employer: _____

Emergency Contact: _____Relationship to child: _____ Phone: _____

(not in household)

Primary Insurance

(The only insurance we file secondary is BCBS. Please give your primary and secondary card to the receptionist)

Insured's Name: _____ DOB: ___/___/_____SS#_____

Relation to Patient: _____ Insurance Co: _____

Insurance ID#_____ Group #_____Ins Eff. Date___/___/_____

Deductible $_____ Co-pay for OV $_____ Co-pay for labs, shots, etc. $_____

Assignment of Benefits

I hereby authorize payment directly to The Children's Clinic, PLLC for all insurance benefits otherwise payable to me for services rendered. I certify that the information I have reported to The Children's Clinic, PLLC with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information, if requested by my insurance company. I permit a copy of this authorization to be used in such instances. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents.

Responsible Party or Patient (if over the age of 18): _____ **Date**: _____

How did you hear about our office?

□ Website/Internet Search □ Friend □ Physician □ Yellow Pages □ Parents & Kids or other magazine □ Other: _____