Patient Information Sheet

** Please attach a copy of the **front & back** of your insurance card **

Please attach a copy of **BOTH parents' Driver's License**

Patient Information

Patient's Full Name: _____ Sex: M or F

Date of Birth: _____ Age: _____

Address:_____ City: _____

Zip: _____County:_____

Mother's Full Name: _____

Mother's Primary #: _____Cell: _____

Mother's Email: _____

Father's Full Name:_____

Father's Primary #: _____Cell: _____

Father's Email:_____

American born: YES or NO Preferred Language: _____

Optional

Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ African American/Black
☐ Caucasian/White
☐ Native Hawaiian or other Pacific Islander

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Insurance

Are you Self Pay? YES or NO

Name of Insurance Company: _____ Policy ID#:_____

Date of Last Physical: _____ *Insurance companies require 365 days between physical exams for children ages 3 and older*

Guarantor's Full Name: _____Guarantor's Date of Birth:_____

Guarantor's SSN#:_____

*A guarantor is the person financially responsible for the patient(s). All About Kids Pediatrics requires a valid Social Security number to establish a guarantor account. *

Pharmacy Preference

Name: _____ Address:_____Phone:_____

Name: _____ Address:_____ Phone:_____