GUARANTOR – PERSON RESPONSIBLE FOR BILL

Last Name: _____Maiden Name: _____ First: _____MI: ___

DOB: _____SS#: _____Day time phone: _____Cell#: _____

Mailing address: _____City/state/zip: _____

PATIENT INFORMATION

Last Name: _____First: _____MI: _____

Sex: M____F____ Date of Birth: _____SS#: _____

Are you Visually or Hearing Impaired? Y___N___ If yes, will you require any special services? Y___N___

If YES, please identify what services you will require. _____

Will you be immunizing your child? Y__N__

FAMILY INFORMATION – IF PATIENT IS CHILD

Mother's Name: _____Employer: _____Work #: _____

DOB: _____SS#: _____Cell #: _____

Father's Name: _____Employer: _____Work #: _____

DOB: _____SS #: _____Cell #: _____

1st Emergency Contact: _____	2nd Emergency Contact: _____
Relation: _____	Relation: _____
Phone #: _____ Cell #: _____	Phone #: _____ Cell #: _____
Employment: _____	Employment: _____
Wk PH #: _____	Wk PH #: _____

Patient Insurance/Salud: _____PCP: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

_____NAME OF COMPANY_____

_____POLICY HOLDER NAME_____

_____RELATIONSHIP TO PT_____

_____SS #/ DOB_____

_____GROUP# _____

_____ID #_____

_____COPAY/DEDUCTIBLE_____

OTHER SIBLINGS:

Name: _____DOB: _____SS#: _____

Name: _____DOB: _____SS#: _____

Name: _____DOB: _____SS#: _____

Name: _____DOB: _____SS#: _____

Babysitter's name: _____Phone: _____

☐ Need Copy of Insurance/Medicaid Card