



PRIORITY CARE PEDIATRICS

Preferred Provider:				Today's date:			
PATIENT INFORMATION (PLEASE PRINT)							
Last name:		First:		Middle:		Preferred Name:	
Birth date: / /		Age:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Transgender <input type="checkbox"/> F to M <input type="checkbox"/> M to F <input type="checkbox"/> _____			
Street address:				Social Security no.:		Primary phone no.: ()	
P.O. box:		City:			State:		ZIP Code:
Email:							
For federal requirements, we request the following information; please choose only ONE each:							
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> African-American							
<input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline to Provide							
Ethnicity: (Heritage, f.ex. American, Costa Rican, Vietnamese):				Preferred Language:			
Parent/Guardian #1:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /	Social Security No:	Primary phone no.:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other
Address (if different):		<input type="checkbox"/> Same as patient	Employer:		Secondary phone no.:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other
			Occupation:		()		
Parent/Guardian #2:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /	Social Security No:	Primary phone no.:		
Address (if different):		<input type="checkbox"/> Same as patient	Employer:		Secondary phone no.:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other
			Occupation:		()		
Sibling(s)' name(s):							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Primary phone no.:		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other	
Address (if different):				Secondary phone no.:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other	
				()			
Primary insurance							
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
Secondary insurance (if applicable):							
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:		Policy no.:	Co-payment:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Primary phone no.:	Secondary phone no.:	
					()	()	
WE WOULD LIKE TO KNOW							
How did you hear about us? (current patient family, family, friend, Facebook, Google, etc.)							

KANSAS CITY NORTH OAK - 9405 N. Oak Trafficway • Kansas City, Missouri 64155
 LIBERTY - 1540 NE 96th Street • Liberty, Missouri 64068
 PARKVILLE - 6320 N Lucerne Ave. • Kansas City, Missouri 64151

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