PRIORITY CARE PEDIATRICS

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