Pediatric Associates of Elizabethtown, PLLC

PATIENT INFORMATION

Sex: ( ) M ( ) F

Name: ______________________________ Date of Birth: ______________________________

Address: ______________________________ Social Security #: ______________________________

City, State: ______________________________ Primary Phone # ______________________________

NAME OF SIBLINGS

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EMERGENCY CONTACTS (other than parents)

Name: ______________________________

Phone: ______________________________

MOTHER OR PRIMARY GUARDIAN

Name: ______________________________

Address: ______________________________

City, State: ______________________________

Phone: ______________________________

Cell Phone: ______________________________

Work Phone: ______________________________

Employer: ______________________________

Social Security #______________________________

Date of Birth: ______________________________

E-mail Address: ______________________________

FATHER

Name: ______________________________

Address: ______________________________

City, State: ______________________________

Phone:______________________________

Cell Phone: ______________________________

Work Phone: ______________________________

Employer: ______________________________

Social Security #______________________________

Date of Birth: ______________________________

E-mail Address:______________________________

Would you like reminders via ( ) Phone ( ) Text ( ) E-mail [mark all that apply]

PRIMARY INSURANCE

Policyholder: ______________________________ Relationship to Primary Insured/Guarantor: ______________________________

Ins Phone: ______________________________ Social Security #: ______________________________

Name of Insurance______________________________ Insured ID# ______________________________

Date of Birth: ______________________________ Policy Group # ______________________________

SECONDARY INSURANCE

Policyholder: ______________________________ Relationship to Primary Insured/Guarantor: ______________________________

Ins Phone: ______________________________ Social Security #: ______________________________

Name of Insurance______________________________ Insured ID# ______________________________

Date of Birth: ______________________________ Policy Group #______________________________

PHARMACY/LOCATION ______________________________