★ PLEASE PRINT ALL INFORMATION CLEARLY ★

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ SEX: □ MALE □ FEMALE

PATIENT ADDRESS: _____
STREET APT# CITY STATE ZIP

MOTHER'S MAIDEN NAME: _____

PREFERRED JOURNEY MEDICAL PROVIDER: _____

SIBLINGS (FULL NAME):
_____
_____
_____

ETHNICITY/RACE/LANGUAGE

ETHNICITY: □NON-HISPANIC □HISPANIC

□ SPANIARD □ CENTRAL AMERICAN
□ MEXICAN □ SOUTH AMERICAN
□ LATIN AMERICAN □ CUBAN
□ PUERTO RICAN □ DOMINICAN

RACE: □ AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN □ WHITE
□ BLACK OR AFRICAN AMERICAN □ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
□ OTHER:_____

PREFERRED LANGUAGE: _____ ADDITIONAL LANGUAGE(S): _____

PLEASE COMPLETE ALL INFORMATION FOR PARENTS/GUARDIAN(S)

***GUARDIAN/ MOTHER NAME**: _____
LAST FIRST MI

RELATIONSHIP TO PATIENT (PLEASE BE SPECIFIC): _____ ***SSN**: XXX - XX -_____ ***DOB**: _____

***ADDRESS**: _____
STREET APT# CITY STATE ZIP

***CELL PHONE**: (____)_____ WORK PHONE: (____)_____ ***HOME PHONE**: (____)_____

OCCUPATION: _____ EMPLOYER NAME: _____

***GUARDIAN/ FATHER NAME**: _____
LAST FIRST MI

RELATIONSHIP TO PATIENT (PLEASE BE SPECIFIC): _____ ***SSN**: XXX - XX -_____ ***DOB**: _____

***ADDRESS**: _____
STREET APT# CITY STATE ZIP

***CELL PHONE**: (____)_____ WORK PHONE: (____)_____ ***HOME PHONE**: (____)_____

OCCUPATION: _____ EMPLOYER NAME: _____

***THESE ARE REQUIRED FIELDS FOR INSURANCE PURPOSES**

CONTINUE TO OTHER SIDE

PARENTS: □ MARRIED □ SINGLE □ DIVORCED

PATIENT LIVES WITH: □ BOTH PARENTS □ MOTHER □ FATHER
□ GRANDPARENTS □ OTHER: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN PARENT:

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE: (_____)_____

PLEASE PROVIDE ALL INSURANCE INFORMATION FOR EVERY POLICY YOUR CHILD IS COVERED UNDER:

PRIMARY INSURANCE INFORMATION

***NAME OF INSURED PARENT/GUARDIAN**: _____

***INSURANCE NAME**: _____ PHONE NUMBER: _____

***INSURANCE ID**: _____ ***GROUP NUMBER**: _____

SECONDARY INSURANCE INFORMATION

***NAME OF INSURED PARENT/GUARDIAN**: _____

***INSURANCE NAME**: _____ PHONE NUMBER: _____

***INSURANCE ID**: _____ ***GROUP NUMBER**: _____

***THESE ARE REQUIRED FIELDS FOR INSURANCE PURPOSES**

PLEASE NOTE: CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND CASH PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

MEDICAL CARE: I AUTHORIZE THE MEDICAL PROVIDERS AND STAFF OF THIS OFFICE TO PROVIDE MYSELF OR MY CHILD WITH REASONABLE AND PROPER MEDICAL CARE ACCORDING TO TODAY'S STANDARDS.

MEDICAL INFORMATION: I AUTHORIZE THE MEDICAL PROVIDERS AND STAFF OF THIS OFFICE TO RELEASE ANY INFORMATION THEY HAVE ACQUIRED IN THE COURSE OF MY OR MY CHILD'S TREATMENT TO MY INSURANCE COMPANY, MY EMPLOYER OR ANY THIRD PARTY PAYER SO THAT THEY MAY OBTAIN PAYMENT FOR MEDICAL SERVICE(S) RENDERED.

INSURANCE AUTHORIZATION: I AUTHORIZE THE MEDICAL PROVIDERS AND STAFF OF THIS OFFICE TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S), CONCERNING MYSELF OR MY CHILD'S ILLNESS AND TREATMENTS.

ASSIGNMENT OF BENEFITS: I AUTHORIZE MY INSURANCE COMPANY OR ANY THIRD PARTY PAYER TO PAY ANY BENEFITS DUE DIRECTLY TO THIS OFFICE SHOULD THEY ACCEPT ASSIGNMENT ON MY CLAIM. I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

PLEASE BE ADVISED THAT A MEDICAL PROVIDER-PATIENT RELATIONSHIP WITH THIS PRACTICE IS NOT ESTABLISHED BY COMPLETING THIS FORM OR ANY PRELIMINARY HEALTH AND/OR INSURANCE QUESTIONNAIRES.