Hilliard Pediatrics Inc.

New Patient Information Form

Patient: _____
Last *First* *MI* *Prefer to be called*

Date of Birth: _____ SS# _____ Gender: ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Primary Doctor: _____

Siblings Names (in this practice): _____

Legal Guardian #1 _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Email Address: _____

Legal Guardian #2 _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Email Address: _____

If parents are divorced or separated, please provide the following information:

Who has custody?_____ Primary parent to contact:_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about that child's medical records and/or treatment?_____

If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____

_____

_____

Emergency Contact: _____ Phone #:_____
(other than parent) Relationship to Patient: _____

Insurance/Billing Information

1.) Primary Insurance Company:_____

2.) Secondary Insurance Company:_____

How would you like to receive reminders? *(circle one)* Phone Text Phone Number_____

If phone call, preferred time of day: ☐ Morning ☐ Afternoon ☐ Evening

I certify the information above is complete and correct.

X_____ Date:_____