

PATIENT INFORMATION



(Please answer all questions....thank you)

Patient's Name _____ Nickname _____ School _____

Date of Birth _____ Sex (Circle One) Male Female Phone Number _____

Patient's Address _____ City _____ St _____ Zip _____

Siblings:

Name _____ Date of Birth _____ School _____

Name _____ Date of Birth _____ School _____

Name _____ Date of Birth _____ School _____

Name _____ Date of Birth _____ School _____

How did you hear about AACCP? _____ Have you seen any of our advertising? Yes No

If so, where did you last see our advertising? _____

If a referral from one of our parents, can you tell us their name so we can thank them? _____

CONTACT INFORMATION

Mother's Name _____ Date of Birth _____

Address (if different) _____ City _____ St _____ Zip _____

SS# _____ Driver's License # _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Place of Employment _____ Occupation _____

If there is a stepfather that may bring in your child periodically, please provide information below:

Name _____ Contact Phone _____

Father's Name _____ Date of Birth _____

Address(if different) _____ City _____ St _____ Zip _____

SS# _____ Driver's License # _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Place of Employment _____ Occupation _____

If there is a stepmother that may bring in your child periodically, please provide the information below:

Name _____ Phone _____

Emergency Contact (other than Parents):

Name _____

Relationship to Patient _____ Phone Number _____

Insurance Information:

Insurance Co _____ Phone Number _____

Address _____

Name of Insured Party (who carries the insurance) _____ Date of Birth _____

SS# _____ Employer _____

ID # _____ Group # _____

Your signature below indicates financial responsibility for all charges incurred and your assignment of insurance benefits to All About Children Pediatrics. This is a legally binding agreement for All About Children Pediatrics to treat and care for your child. Please note that payment is due at time of service unless prior arrangements have been made and agreed to. **WE WILL NEED TO COPY YOUR INSURANCE CARD. IF YOU HAVE QUESTIONS, PLEASE ASK THE RECEPTIONIST.**

Signature

Date