Patient Information:

Child's Name:_____ Nickname:_____
Address:_____ City:_____ State:___ Zip:_____
Phone: (____)_____ Parent's Cell: (____)_____
Patient DOB: ____/____/_____ Patient SSN#: _____/_____/_____
Name of School Child Attends:_____

Parent / Guardian Info:

Mother's Name:_____
Mother's Phone:_____ Best time to reach:_____
Mother's e-mail:_____

Father's Name:_____
Fathers's Phone:_____ Best time to reach:_____
Father's e-mail:_____

Address (if different than above):_____
City:_____ State:_____ Zip:_____
How did you find out about us:_____

Insured Parent Information:

(Please attach copy of front and back of Insurance Card.)

Name of Insured:_____ Insured DOB:_____
Relationship to patient:_____ Insured SSN#:_____
Name of employer:_____ Work Phone:_____
Address of employer:_____
City:_____ State:_____ Zip:_____
Name of Insurance Co:_____
Group #_____ ID#_____
Member Service Phone # (_____)_____ *(located on back of insurance card)*
Provider Service Phone (_____)_____ *(located on back of insurance card)*

Do you have additional Insurance? If yes, complete the following:

Name of Insured:_____ Insured DOB:_____
Relationship to patient:_____ Insured SSN#:_____
Name of employer:_____ Work Phone:_____
Address of employer:_____
City:_____ State:_____ Zip:_____
Name of Insurance Co:_____
Group#_____ ID#_____
Member Service Phone #_____ Provider Service Phone _____