PATIENT INFORMATION

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

Patient's Name ______________________ Nickname ____________ School ____________
Date of Birth ____________ Sex (Circle One) M F Ethnicity: Black White Hispanic Asian Other ________
Patient's Address ______________________ City ____________ St _____ Zip ________
Phone Number ________________ Language English, Spanish Other ________
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 AACP? ________________ 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 then 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. THE PERSON WHO BRINGS THE DEPENDENT CHILD TO THIS OFFICE IS RESPONSIBLE FOR ANY COPAY OR ACCT BALANCE. 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 AND DRIVER LICENSE. IF YOU HAVE QUESTIONS, PLEASE ASK THE RECEPTIONIST.**

______________________________ ______________________
Signature Date