

Pediatric Associates of Elizabethtown, PLLC

PATIENT INFORMATION

Sex: () M () F

Name: _____ Date of Birth: _____
Ethnicity(Required): _____ Race: _____
Address: _____ Social Security #: _____
City, State: _____ Primary Phone #: _____

SIBLINGS SEEN

EMERGENCY CONTACTS (other than parents)

HERE UNDER 21

Name: _____

Phone: _____

MOTHER OR PRIMARY GUARDIAN

FATHER

Name: _____ Name: _____
Address: _____ Address: _____
City, State: _____ City, State: _____
Phone: _____ Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____
Employer: _____ Employer: _____
Social Security #: _____ Social Security #: _____
Date of Birth: _____ Date of Birth: _____
Would you like reminders via () Phone () Text () E-mail _____ [mark all that apply]

PRIMARY INSURANCE

Relationship to Primary _____
Policyholder: _____ Insured/Guarantor: _____
Insurance Phone: _____ Social Security #: _____
Name of Insurance _____ Insured ID# _____
Date of Birth: _____ Policy Group # _____

SECONDARY INSURANCE

Relationship to Primary _____
Policyholder: _____ Insured/Guarantor: _____
Ins Phone: _____ Social Security #: _____
Name of Insurance _____ Insured ID# _____
Date of Birth: _____ Policy Group # _____

PHARMACY NAME/LOCATION:

Prescription Company: _____ Phone #: _____
RxBIN: _____ RxGRP: _____ RxPCN: _____ Member ID: _____