GENERATIONS
Pediatrics & Internal Medicine

PATIENT INFORMATION FORM

LAST NAME	FIRST NAME	PREFERRED NAME	MIDDLE INITIAL	
DATE OF BIRTH	SS#	GENDER AT BIRTH		PRIMARY LANGUAGE
MAILING ADDRESS		CITY/STATE	ZIP CODE	
MOBILE PHONE		HOME PHONE		WORK PHONE

GUARANTOR (If older than 18, patIent will be listed as guarantor. Guarantor is legally responsible for any balance due)

LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO PATIENT	
DATE OF BIRTH		SS#		EMPLOYER
MAILING ADDRESS		CITY/STATE	ZIP CODE	
MOBILE PHONE		HOME PHONE		WORK PHONE

EMERGENCY CONTACT (For pediatric patient list contact other than parent)

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

PARENT/GUARDIAN & IMMEDIATE FAMILY INFORMATION (Pediatric Patients Only)

MOTHER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SS#
HOME ADDRESS		CITY/STATE		ZIP CODE
MOBILE PHONE		WORK PHONE		EMPLOYER
FATHER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SS#
HOME ADDRESS		CITY/STATE		ZIP CODE
MOBILE PHONE		WORK PHONE		EMPLOYER

Patient Name _____ DOB _____

(Pediatric Patients Only) Brothers, Sisters & Other Family Members

Full Name	*M or F*	*Date of Birth*	*Relationship*	*Lives with child*	
				Yes	No
				Yes	No
				Yes	No
				Yes	No

☐ Check here if no insurance. And, skip to Authorization (below).

Accident Information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐Yes ☐No

Type of Accident: _____ Date of Accident: _____ County of Accident: _____

Primary Insurance Information

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____

Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: ☐Male ☐Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ Phone: _____

Policy/Cert #: _____ Group No: _____ Effective Date: _____

Subscriber Status: ☐Full-Time ☐Part-Time ☐Self Employed ☐Active Military ☐Student Full Time
☐Student Part-Time ☐Retired Date _____ ☐Disabled ☐Not Employed

Secondary Insurance Information

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____

Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: ☐Male ☐Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ Phone: _____

Policy/Cert #: _____ Group No: _____ Effective Date_____

Subscriber Status: ☐Full-Time ☐Part-Time ☐Self Employed ☐Active Military ☐Student Full Time
☐Student Part-Time ☐Retired Date _____ ☐Disabled ☐Not Employed

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Generations Pediatrics and Internal Medicine for services rendered. I will be responsible for any amount not covered by my insurance company.

Signature of Patient/Guardian/Guarantor: _____ Date:_____