



# GENERATIONS

Pediatrics & Internal Medicine

PATIENT INFORMATION FORM

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LAST NAME	FIRST NAME	PREFERRED NAME	MIDDLE INITIAL
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DATE OF BIRTH	SS#	GENDER AT BIRTH	PRIMARY LANGUAGE
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MAILING ADDRESS	CITY/STATE	ZIP CODE
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MOBILE PHONE	HOME PHONE	WORK PHONE
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**GUARANTOR** (If older than 18, patient will be listed as guarantor. Guarantor is legally responsible for any balance due)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO PATIENT
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DATE OF BIRTH	SS#	EMPLOYER
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MAILING ADDRESS	CITY/STATE	ZIP CODE
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MOBILE PHONE	HOME PHONE	WORK PHONE
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**EMERGENCY CONTACT** (For pediatric patient list contact other than parent)

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NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
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**PARENT/GUARDIAN & IMMEDIATE FAMILY INFORMATION (Pediatric Patients Only)**

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