WELCOME TO THE INTERNATIONAL PEDIATRIC CLINICS

How did you hear about our clinic? ☐ ESTABLISHED PATIENT ☐ YELLOW PAGES ☐ OUTSIDE SIGN

☐ FRIEND ☐ FESTIVAL ☐ NEWSPAPER ☐ INSURANCE COMPANY ☐ OTHER (specify):

PATIENT INFORMATION

Patient's Name:	Sex: ☐ M ☐ F	Date of Birth	SSN#:
Address	City/State	Zip Code:	Home Telephone
Mother's Name:		Date of Birth	Cell Phone Number:
Mother's Employer	Work Address	City/State	Work Number:
Father's Employer:		Date of Birth	Cell Phone Number:
Father's Employer	Work Address	City/State	Work Number:
Name of Person to call in case of an emergency:		Telephone Number:	

INSURANCE INFORMATION

☐ Medicaid ☐ Peachcare	Insurance ID Number:	Telephone Number:	
☐ Other Insurance	Name of Insurance Company:	Insurance ID Number:	Group Number:
Name of Responsible Party:	Relationship to Patient: ☐ Mother ☐ Father ☐ Other		

Name of the Pharmacy that you use? City		Pharmacy Telephone Number?
Name of your child's previous pediatrician?	Telephone Number?	When was your child last seen there?

AUTHORIZATION

Please show your insurance card to the receptionist.
I authorize International Pediatric Clinics to share information with and to receive payments from the insurance company whom I have an active contract.
Please return this form to the receptionist.

My signature will confirm that all the information provided above is to my knowledge true and correct:

Sign: _____ Date: _____

High quality pediatrics with love and without boundaries

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