Patient's FULL Name: _____ **Birthdate:** _____ M / F

Street: _____ **City:** _____ **State:** _____

Zip Code: _____ **Primary phone#:** _____ **Social Security #:** _____

Race: __ American Indian/Alaska Native __ Asian __ Black/African American

__ White __Other __Native Hawaiian/Pacific Islander

Ethnicity __ Hispanic/Latino __ non-Hispanic/Latino

Father/Guardian: _____ **Address & Zip:** _____

Birthdate: _____ SS#: _____ **Home phone:** _____

Employer: _____ **work phone:** _____

Occupation: _____ **Cell phone:** _____

Mother/Guardian: _____ **Address & Zip:** _____

Birthdate: _____ SS#: _____ **Home phone:** _____

Employer: _____ Work **phone:** _____

Occupation: _____ Cell **phone:** _____

Primary Physician: _____

Emergency Contact <u>OTHER THAN PARENT</u>: Name: _____ **Phone:** _____

Primary Insurance: _____ **Identification #:** _____

Name of Policyholder: _____ **Social Security #:** _____

Address: _____ **Employer:** _____

Birthdate: _____ **Relationship to PT:** _____ **Phone:** _____

Secondary insurance: _____ **Identification #:** _____

Name of policyholder: _____ Social **Security #:** _____

Address: _____ **Employer:** _____

Birthdate: _____ **Relationship to PT:** _____ **Phone:** _____

I hereby authorize the payment of all medical benefits to PEDIATRIC HEARTCARE PARTNERS. I understand that I am responsible for any/all charges not paid by insurance. I authorize the office of PEDIATRIC HEARTCARE PARTNERS to obtain or release any of my/my child's information for medical, insurance or billing purposes.

Signature: _____ Date: _____