Hilliard Pediatrics Inc.

New Patient Information Form

Patient: _____

Last *First* *MI* *Prefers to be called*

Date of Birth: _____ SS#: _____ Gender: ☐Male ☐Female

Race: _____ Ethnicity: _____

Siblings Names (in this practice): _____

Legal Guardian #1 _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Phone: _____ OK to Text? ☐Yes ☐No

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Insurance Carrier: _____ Policy #: _____ Policy Holder: ☐Self ☐Other

Email Address: _____ ☐ Register for Patient Portal

Legal Guardian #2 _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Phone: _____ OK to Text? ☐Yes ☐No

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Insurance Carrier: _____ Policy #: _____ Policy Holder: ☐Self ☐Other

Email Address: _____ ☐ Register for Patient Portal

If parents are divorced or separated, please provide the following information:

Who has custody?_____ Primary parent to contact:_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about that child's medical records and/or treatment?_____

If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____

_____

_____

Emergency Contact: _____ Phone #:_____

(other than parent) Relationship to Patient: _____

Contact Preferences:

Primary contact for appointments: _____ Primary contact for insurance/billing: _____

How would you like to receive appointment reminders? *(circle one)* Phone Text Phone Number: _____

If phone call, preferred time of day: ☐ Morning ☐ Afternoon ☐ Evening

I certify the information above is complete and correct.

X_____ Date:_____