All About Children Pediatrics

Adult Patient Information Form

Please complete entire form with current and accurate information

Patient (You)

Legal Last Name:	Legal First Name:	Middle Initial:	Nickname:
Date of Birth:	Gender: ☐ Male ☐ Female	Social Security #:	
Race: (list all that apply)	Primary Language:	Birth Country:	
Home Phone: ( )	Email Address:		
Cell Phone: ( )	New Patient Portal: Sign me up for Patient Portal Access (requires an email): Yes ☐ No ☐		

Primary Home Address

Street Address:		
City:	State:	Zip:

(*circle* who you live with the majority of the time)

Self ☐ *Both Parents* ☐ *Mom* ☐ *Dad* ☐ *Grandparent* ☐ *Sibling* ☐

Parent Information (provide if you are 18-26 years of age)

Mother's Legal Name:			Father's Legal Name:		
Address:			Address: (if different from Mother)		
City:	State:	Zip:	City:	State:	Zip:
Birthdate:	SS #: (if known)		Birthdate:	SS #: (if known)	
Home Phone: ( )	Cell Phone: ( )		Home Phone: ( )	Cell Phone: ( )	
Employer:	Employer Phone:		Employer:	Employer Phone:	
I give All About Children Pediatrics permission to discuss my account/medical care with my Mother (Initial on line of your choice): YES_____ NO _____			I give All About Children Pediatrics permission to discuss my account/medical care with my Father (Initial on line of your choice): YES _____ NO _____		

Billing Information (*Please be prepared to present your insurance card – Co-pays are due at the time of service*)

Primary Insurance Name:	Name of Policy Holder:	Effective Date:
	Relation to Policy Holder: ☐ Self ☐ Child	
Secondary Insurance Name:	Name of Policy Holder:	Effective Date:
	Relation to Policy Holder: ☐ Self ☐ Child	

Emergency Contact: (other than parent)	Relationship to Patient (You):
Home Phone:	Cell Phone:

Please list the phone number we should call to confirm your upcoming appointments: _____

All About Children can leave a message at the above listed phone number (Initial for your response, *do not check*): YES _____ NO _____

Patient Signature: _____ Date: _____