Welcome to Pediatrics West

Thank you for choosing our practice. All information will be STRICTLY CONFIDENTIAL

Today's Date _____

Patient's Name _____ Date of Birth _____
(Last) (First) (MI)

Street Address _____ Sex: M F

City _____ State _____ ZIP _____

Main Phone # _____ Patient's Cell # (if over 13) _____

E-mail Address _____

Parent/Guardian 1 _____ Parent/Guardian 2 _____

Address_____ Address _____

_____ _____

Phone # _____ Phone # _____

Relationship to Patient _____ Relationship to Patient _____

Date of Birth _____ Date of Birth _____

Siblings: Name _____ Date of Birth _____

Name _____ Date of Birth _____

Subscriber Information (person who carries insurance)

Subscriber Name _____

Street Address_____

City _____ State_____ ZIP _____

Phone # _____ Social Security Number_____

Relationship to Patient _____ Phone # _____

Guarantor Information (person who will by primarily responsible for paying balances)

Guarantor Name_____ Phone #_____

Emergency Contact (other than parent/guardian)_____

Emergency Contact Phone #_____ Emergency Contact Phone #_____

Optional

Race (circle) *Asian* *Black/African American* *Caucasian* *Chinese* *Hispanic* *Japanese*
American Indian or Alaskan Native *Latino* *Multiracial* *Pacific Islander* *Other* _____

Ethnicity (circle) *Hispanic* *Non-Hispanic* *White* *Other* _____

Language (circle) *English* *French* *German* *Hindi* *Mandarin* *Spanish* *Vietnamese* *Other* _____