CHART # _____

PEDIATRIC PATIENT INFORMATION
ORTHOPEDIC GROUP OF BIRMINGHAM

PLEASE READ CAREFULLY AND COMPLETE AS THOROUGHLY AS POSSIBLE. THIS IS TO ENSURE YOU THE BEST SERVICE AVAILABLE.

PATIENTS NAME: _____ **AGE:** _____ BIRTHDATE: _____

SS #: _____ SEX: M F PATIENT LIVES WITH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____ CELL: _____

MOTHER'S NAME: _____ SS# _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ E-MAIL: _____

EMPLOYER: _____ CELL: _____ OTHER: _____

FATHER'S NAME: _____ SS# _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ E-MAIL: _____

EMPLOYER: _____ CELL: _____ OTHER: _____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT: _____

MAILING ADDRESS: _____ TELEPHONE: _____ CELL: _____

PRIMARY CARE DOCTOR: _____ **REFERED BY:** _____

NAME OF PHARMACY: _____ **PHONE #:** _____

ADDRESS: _____

PATIENT PORTAL: PLEASE CIRCLE ONE **YES,** I am interested. **NO,** I am not interested.

INSURANCE INFORMATION: PLEASE COMPLETE THIS SECTION:

PRIMARY INSURANCE: _____

POLICY HOLDER NAME: _____ SS#: _____

DATE OF BIRTH: _____ EFFECTIVE DATE: _____

CONTRACT #: _____ GROUP #: _____

SECONDARY INSURANCE: _____

POLICY HOLDER NAME: _____ SS#: _____

DATE OF BIRTH: _____ EFFECTIVE DATE: _____

CONTRACT #: _____ GROUP #: _____

PLEASE PRESENT INSURANCE CARD (S)

_____ _____

SIGNATURE **DATE**