Midtown Pediatrics
Contact and Insurance Information

Patient Name : ____________________________________circle **M F** Date of Birth: ______________
first **middle** **last**

Address:____
City **State** **Zip**

Primary Phone #:_____________________________________

Race: ☐American Indian/Alaskan ☐Asian ☐ Black ☐White

☐Pacific Islander ☐Declined to answer

Primary Language if not English: ________________________

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Declined to answer

Guardian/Guarantor Information

Parent/Guardian #1 Name____ DOB: _____________

Relation to Patient:☐ Father ☐Mother ☐Step-Father ☐Step-Mother ☐Legal Guardian

Address: ____
(if different from patient) **City** **State** **Zip**

Cell Phone:_____________________ Email: ____

Employer/Occupation:__________________________________Work Phone: ____________________

Parent/Guardian #2 Name____ DOB: _____________

Relation to Patient:☐ Father ☐Mother ☐Step-Father ☐Step-Mother ☐Legal Guardian

Address: ____ ________________________________
(if different from patient) **City** **State** **Zip**

Cell Phone:_____________________ Email: ____

Employer/Occupation:__________________________________Work Phone: ____________________

(see other side)

Insurance Information

First and Last Name of person responsible for the bill:________________________________
Insurance Name__________________________________ID#:__________________________
Group#:___________________
Secondary Insurance:_____________________________ID#:__________________________
Group#:___________________
Self Pay/No Insurance: ☐

Contact Preference

Which pharmacy do you prefer? (name and location)____

Who would you like us to contact by phone regarding results, billing, and other medical issues?
Please enter two choices if possible.
First Choice
Name:__________________________Relationship:_______________Phone:_______________
Second Choice
Name:__________________________Relationship:_______________Phone:_______________

Reminders

We prefer to send appointment reminders by text. Patients have found this very helpful. If you agree to receive appointment reminders sign here:

X____

Preferred Ph # for text reminder if different from Primary Ph #:___________________________
If you prefer email reminder instead of text write email address:__________________________

Emergency Contact

Friend/Relative (not living with you):____

Relationship to Patient:____________________________ Phone: ________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize to release any information required to process my claims.

Signature of Parent/Legal Guardian:

X____ Date:_________________

Printed Name____