Date: _____

# Crestwood Pediatric Associates, PC

Reviewed by: _____
Account #:

## Parent/Legal Guardian Information

Mother's Name _____ Date of Birth _____ SSN _____

Address: _____

Phone _____ _____ _____
Cell Work Email

Father's Name _____ Date of Birth _____ SSN _____

Address: _____

Phone _____ _____ _____
Cell Work Email

**Preferred Pharmacy:** _____
Name Address Phone

## Patient Information- <u>Please list all children coming to our practice.</u>

_____DOB ___/___/_____M / F. Race _____Ethnicity_____
Last name First name middle initial

_____DOB ___/___/_____M / F. Race _____Ethnicity_____
Last name First name middle initial

_____DOB ___/___/_____M / F. Race _____Ethnicity_____
Last name First name middle initial

_____DOB ___/___/_____M / F. Race _____Ethnicity_____
Last name First name middle initial

_____DOB ___/___/_____M / F. Race _____Ethnicity_____
Last name First name middle initial

## Insurance Information

Do you have insurance? Yes _____ No _____ (If no, you will be expected to pay for today's visit at check-out.)

_____ _____ _____
**Primary Insurance Company** ID Number Group Number

**Policy Holder:** Mom / Dad / Other: (please circle) If other please complete the following:

_____
Name DOB SSN Address

_____ _____ _____
**Secondary Insurance Company** ID Number Group Number

**Policy Holder:** Mom / Dad / Other: (please circle) If other please complete the following:

_____
Name DOB SSN Address

**SIGNATURE OF PARENT/LEGAL GUARDIAN** _____

**I AUTHORIZE CRESTWOOD PEDIATRIC TO BILL MY HEALTH INSURANCE AS PROVIDED ABOVE. I ACKNOWLEDGE THAT PAYMENT OF COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**

Revised 07/01/2025