Patient Information Form

Premier Pediatrics
Washington University Clinical Associates

Please List All Children Who Are Patients in the Practice

First Name	MI	Last Name	Gender	DOB	Primary Doctor	Cell
			M / F			
			M / F			
			M / F			
			M / F			
			M / F			

Parent or Guardian Information

Name:			Other Parent/Guardian:		
Relationship to Patient: Mom / Dad / Other			Relationship to Patient: Mom / Dad / Other		
DOB:	SS#: - -		DOB:	SS#: - -	
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Employer:			Employer:		
Home Phone:	Cell:		Home Phone:	Cell:	
Work Phone:			Work Phone:		
Email:			Email:		

Miscellaneous Information

Patient Lives With:	Referred By:
Names / Relationship of Other Caretakers Who May Bring Patient to the Office:	
Emergency Contact (non-guardian) Name / Relationship / Phone:	
Primary Language:	Do You Need an Interpreter?

Insurance Information

Insurance Carrier:	Group #:	ID#:
Subscriber's Name:	Subscriber SS#: - -	Subscriber DOB:

By signing this form, I agree that the information provided above is correct. I have received, read, and understood the Notice of Privacy practices of the clinic. I give my permission to have my child's(ren's) immunization record faxed directly to their school or daycare.

Filled Out By:	Relationship:
Signature	Date: