Northside Pediatrics, P.C.

CHILD'S NAME__________________________________DATE OF BIRTH_________ SEX____

ADDRESS_________________________CITY____________STATE__________ZIP__________

CHILD'S SS#_____________________________

FATHERS INFORMATION

NAME____________________________________

ADDRESS_________________________________

SS#_____________________________________

DATE OF BIRTH___________________________

HOME PHONE______________________________

WORK PHONE______________________________

PLACE OF EMPLOYMENT_____________________

NAME OF INSURANCE FOR CHILD

____

INSURANCE #'S

____

MOTHERS INFORMATION

NAME____________________________________

ADDRESS_________________________________

SS#_____________________________________

DATE OF BIRTH___________________________

HOME PHONE______________________________

WORK PHONE______________________________

PLACE OF EMPLOYMENT_____________________

INSURANCE FOR CHILD

____

INSURANCE #'S

____

MEDICAID #'S FOR CHILD___________________

NEAREST RELATIVE________________________ RELATIONSHIP TO PATIENT______________

ADDRESS OF RELATIVE_____________________ PHONE # OF RELATIVE__________________

FRIEND OR NEIGHBOR______________________ PHONE OF FRIEND______________________

EMERGENCY CONTACT NAME AND NUMBER____

OTHER CHILDREN IN FAMILY

NAMES	DATE OF BIRTH
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

SIGNATURE OF PARENT/GUARDIAN

____

TODAY'S DATE

____

DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT BRINGING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR THE BILL. WE CANNOT BILL THE OTHER PARENT. IF SOMEONE OTHER THAN YOURSELF I S RESPONSIBLE FOR THE PAYMENT OF THE BILL, IT IS YOUR RESPONSIBILITY TO SEE THAT THE PARTY RECEIVES A COPY OF THE BILL.

Patient Demographics