Silver Sage Center for Family Medicine

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Silver Sage
CENTER FOR FAMILY MEDICINE

PEDIATRIC PATIENT INFORMATION SHEET

Name

_____
Last First MI Date of Birth

Physical Address_____
Address City State Zip

Mailing Address_____
Address City State Zip

Patient Phone_____ Cell_____ Work _____

Parent E-Mail_____ Sex: M F

Social Security_____ Race_____ Ethnicity_____

Parent/guardian Name(s):_____

Emergency Contact: _____
Name Phone Relationship

What is the best means to contact you: (Please circle one) E-mail Home phone Cell phone or Mail?

Parent Employment Information

Employer: _____

Employer Address: _____

Spouse/Parent: _____ Occupation:_____

Employer: _____ Work Phone: _____

Insurance Information for Child

Name of Subscriber: _____ Relationship to patient: _____

Birth Date of Subscriber: _____ Social Security #: _____

Name of Employer: _____ Work Phone: _____

Insurance Co: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Employer: _____ Subscriber D.O.B: _____

Relationship to patient: _____

I understand that co-payments are due at the time of visit. I authorize payment of medical benefits from my insurance company to Silver Sage Center for Family Medicine. I also authorize the release of any medical information necessary to process any medical claim. **We bill insurance as a courtesy to you**. **You realize that you are responsible for any balance accrued at the time of visit should your insurance company not cover/pay. You acknowledge receipt of the privacy policies and practices notice (paper copy available by request).**

Signature: _____ Date:_____

Is there a friend of family member that we may disclose your medical information with? Name and relation:

_____

How did you hear about us? _____

We do not discriminate against anyone regardless for color, race, creed or physical ability.