

# HUGUENOT PEDIATRICS

## PATIENT INFORMATION

DATE: \_\_\_\_\_

### CHILDREN'S INFORMATION:

1. \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER SEX

2. \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER SEX

3. \_\_\_\_\_  
LAST NAME FIRSTNAME MIDDLE NAME

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER SEX

4. \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER SEX

5. \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER SEX

**HOME ADDRESS:** \_\_\_\_\_  
STREET ADDRESS (NO P.O. BOX) CITY AND STATE ZIP CODE

### MOTHER'S INFORMATION:

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH SOCIAL SECURITY #

\_\_\_\_\_  
EMPLOYER'S NAME AND ADDRESS CITY AND STATE ZIP CODE OCCUPATION

HOME ADDRESS: \_\_\_\_\_  
STREET ADDRESS (NO P.O. BOX) CITY AND STATE ZIP CODE

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

### FATHER'S INFORMATION:

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH SOCIAL SECURITY #

\_\_\_\_\_  
EMPLOYER'S NAME AND ADDRESS CITY AND STATE ZIP CODE OCCUPATION

HOME ADDRESS: \_\_\_\_\_  
STREET ADDRESS (NO P.O. BOX) CITY AND STATE ZIP CODE

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT:** (SOMEONE OTHER THAN YOURSELF) EXAMPLE: GRANDPARENT, AUNT, UNCLE, FRIEND ETC.)

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NAME	RELATIONSHIP TO CHILDREN	PHONE NUMBER
ADDRESS	CITY AND STATE	ZIP CODE

IF YOU ARE A NEW PATIENT: HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

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NAME OF INSURANCE COMPANY	PHONE NUMBER	
SUBSCRIBER NAME	DATE OF BIRTH	RELATIONSHIP TO CHILD

**SECONDARY INSURANCE INFORMATION:**

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NAME OF INSURANCE COMPANY	PHONE NUMBER	
SUBSCRIBER NAME	DATE OF BIRTH	RELATIONSHIP TO CHILD

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**I HEREBY AUTHORIZE HUGUENOT PEDIATRICS, P.C. TO RELEASE INFORMATION REQUESTED BY THE INSURANCE COMPANY/IES. I HEREBY ASSIGN PAYMENTS DIRECTLY TO HUGUENOT PEDIATRICS, P.C. OF BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND MY INSURANCE IS FILED AS A COURTESY AND I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES. IN THE EVENT MY INSURANCE DOES NOT PAY WITHIN 45 DAYS OF DATED FILED I WILL PAY THE BALANCE IN FULL OR MAKE A REASONABLE PAYMENT ARRANGEMENT. IF MY ACCOUNT IS REFERRED TO AN ATTORNEY OR COLLECTOR, I AM RESPONSIBLE FOR ALL ADDITIONAL FEES INCURRED WHICH IS UP TO 40%. I AGREE THE INFORMATION STATED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

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PARENT/GUARDIAN (PRINT)	PARENT SIGNATURE	DATE
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PATIENT IF 18 OR OVER (PRINT)	PATIENT SIGNATURE	DATE
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