

CRAIG RANCH PEDIATRICS

PATIENT INFORMATION SHEET

Welcome to our office! We are happy to serve your healthcare needs. The information requested on this form will enable us to serve you more efficiently. It is also important that this information is kept current. Thank You!

HOW DID YOU HEAR ABOUT OUR OFFICE?

PATIENT/ SIBLING INFORMATION

Name: _____ Date of Birth: _____ M F
Name: _____ Date of Birth: _____ M F
Name: _____ Date of Birth: _____ M F
Name: _____ Date of Birth: _____ M F

Home Phone # _____ Cell Phone # _____

PARENT INFORMATION

Mother's Name _____ Father's Name _____

Address _____ Address _____

City _____ State&Zip _____ City _____ State&Zip _____

Employer _____ Employer _____

Occupation _____ Occupation _____

Driver's License State/# _____ Driver's license State/# _____

S.S.# _____ S.S.# _____

Please check status: Married Single Widowed Separated Divorced

INSURANCE INFORMATION

Insured's Name	Relationship to Patient
Insured's DOB	Insured's S.S.#
Insurance Carrier	

I authorize the release of any medical or other information necessary to process medical claims.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

PARENT'S SIGNATURE _____

DATE _____