

Kagan Pediatrics

Patient Information Sheet

Patient Information:

Children's Names: (first, middle, last)

Sex: ____ DOB: _____ SS#: _____

Sex: ____ DOB: _____ SS#: _____

Sex: ____ DOB: _____ SS#: _____

Sex: ____ DOB: _____ SS#: _____

Patient's(s)' Address: _____

City/State/Zip: _____ **Home Phone:** _____

Is it okay for our staff to leave you a voicemail regarding labs/medical information: Yes No

If yes, what is the best phone number to leave this information? _____

Does your child have health insurance? Yes No **If yes, who is the provider:** _____

How did you hear about us? _____

Parent/Guardian Information:

Mother's Name: _____ **DOB:** _____

SS#: _____ **Driver's License #:** _____

Address: _____ **City/State/Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Employer: _____ **Occupation:** _____

Father's Name: _____ **DOB:** _____

SS#: _____ **Driver's License #:** _____

Address: _____ **City/State/Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Employer: _____ **Occupation:** _____

Emergency Contact Information:

Name of person: _____ **Phone #:** _____

Relationship to Patient(s): _____

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination of my child(ren) during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me.

Signature of Responsible Party: _____ **Date:** _____