PENSACOLA PEDIATRICS, P.A.

We ask for a lot of information. We need it to give your child the care they need, provide you with information and bill your insurance.

Today's Date:_____ Your primary physician here: _____ ID:_____

Patient Last Name: _____ Patient's First Name: _____ Initial: ___

Nickname: _____ Birth Date: _____ SS#: ___-___-_____ ❑ Male / ❑ Female

Patient Address:(Street)_____(City)_____ (State)____(Zip)_____

Primary Phone #: _____-_____-_____

Other Children Seen by Us? ❑ YES / ❑ NO

Ethnicity: ❑Hispanic ❑Not Hispanic ❑Declined

Race: ❑ American Indian ❑ Asian ❑Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other ❑ Declined

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Provide ALL contacts: First (who most often brings child), Second and the Insured

First Parent or Guardian Contact *(Circle One)*

Last Name: _____ First Name: _____ Initial: ___

Social Security #: _____ Date of Birth: _____

Address: (Street)_____ (City)_____ (State)____(Zip)_____

Home Email: _____ Work Email: _____

Employer: _____ Occupation:_____ Insurance Holder? ❑ YES / ❑ NO

Primary Phone #: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Second Parent or Guardian *(Circle One)*

Last Name: _____ First Name: _____ Initial: ___

Social Security #: _____ Date of Birth: _____

Address: (Street)_____ (City)_____ (State)____(Zip)_____

Home Email: _____ Work Email: _____

Employer: _____ Occupation:_____ Insurance Holder? ❑ YES / ❑ NO

Primary Phone #: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

INSURED'S Last Name: _____ First Name: _____ Initial: ___

❑ Male / ❑ Female Birth Date: _____ Relation to Patient: _____

Insurance Carrier: _____ Member ID#: _____

Group #:_____ Group Name: _____ 2nd Insurance? ❑ YES / ❑NO

(If another (secondary) insurance please put information on back)

Patient Balances (co-pays, deductibles, and coinsurance amounts) are due today.