



Please print clearly & fill in ALL the blanks

Name: _____

Last

First

MI

Address: _____

Street/P.O. Box

City

State

Zip Code

Date of Birth: ____/____/____ Male / Female Social Security #: _____

Meaningful Use/Public Reporting: Language: English ___ Spanish ___ Indian ___ Russian ___ Other _____

Race: Caucasian ___ Hispanic ___ Black/African American ___ Alaskan Native or American Indian ___ Asian ___ Native Hawaiian or other Islander ___

Other: _____ N/A ___ Ethnicity: Hispanic or Latin ___ Non-Hispanic or Latin ___ N/A ___

Birth Order: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__

Mother or Guardian's Information:

Father or Guardian's Information:

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Social Security #: _____

Social Security #: _____

Address (if different from above)

Address (if different from above)

Email: _____

Email: _____

Home Phone #: _____

Home Phone #: _____

Cell Phone #: _____

Cell Phone #: _____

Employer: _____

Employer: _____

Is it ok to leave a message/information on your: Home phone? __Y__N Cell Phone? __Y__N Work Phone? __Y__N Do you want to be web enabled? __Y__N

Emergency Contact (Someone other than parent/guardian & this person should be on your consent to treat form):

Relationship to Patient: _____ Phone # _____

Name of Pharmacy: _____ Street/Intersection and City: _____

Insurance Information

Primary Insurance Name _____ Secondary Insurance Co. Name _____

Address: _____ Address: _____

ID Number _____ Group # _____ ID Number _____ Group # _____

Policy Holder _____ Employer _____ Policy Holder _____ Employer _____

Financial Policy

I have read and understand the Financial Policy of Bluffton Pediatrics. I can access the financial policy of the practice on their website www.blufftonpediatrics.com.

Printed name of Parent/Guardian

Signature of Parent/Guardian

Date