KIDS CARE PEDIATRIC ASSOCIATES, PC

New Patient & Family Information Form

Father's Full Name:	**Mother's** Full Name
Social Security #	Social Security #
Date of Birth	Date of Birth
Home Address	Home Address
City, State, Zip	City, State, Zip
Home Phone	Home Phone
Cell Phone	Cell Phone
eMail:	eMail:
Employer	Employer

List All Children's Full Names	Birthdates	Sex

Insurance Information	
Primary Ins. Co.	Secondary Ins. Co.
Father or Mother	Father or Mother
Group#	Group#
ID#	ID#
Phone	Phone

What **Pharmacy** do you usually use: Name: ______________________________ Phone: ________________________

Who may we contact in the case of an emergency:____

Name and Phone of nearest Relative NOT living with you:____

I understand and agree that regardless of my insurance status that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on **both** sides of this form, and have completed the above answers. I certify that the information is true and correct to the best of my knowledge. I will notify you of any changes of the above information.

Signature: ______________________________ Date __________________

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