



# PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex:  M  F

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

	Name	Sex (M/F)	Date of Birth
Siblings:	_____		
	_____		
	_____		

How did you hear about us? \_\_\_\_\_

# PARENT INFORMATION

Parent #1 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address (if different from child) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Contact E-Mail Address: \_\_\_\_\_

Parent #2 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address (if different from child) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Contact E-Mail Address: \_\_\_\_\_

# INSURANCE INFORMATION

*(This information is needed for subspecialist referrals, scheduling procedures, medical equipment, etc)*

**I understand that payment of all medical care is due upon receipt of invoice from Spring Valley Pediatrics and that Spring Valley Pediatrics does not participate with any insurance plans. I hereby grant permission to Spring Valley Pediatrics to release any pertinent information to my insurance company and/or consulting physicians upon request.**

Primary Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness Signature \_\_\_\_\_ Date \_\_\_\_\_