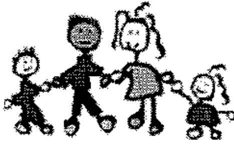

Health Care for Children

an affiliate of Children's Mercy

PATIENT INFORMATION FORM

LAST NAME________________________ FIRST NAME________________________ MI______

ADDRESS________________________ CITY______________ STATE_____ ZIP________

DOB______________ GENDER: M / F

PARENT/GUARDIAN #1________________________________ DOB______________

RELATIONSHIP TO PATIENT__________ EMPLOYER______________ OCCUPATION______________

HOME PHONE________________________ CELL PHONE________________________

WORK PHONE________________________ EMAIL________________________

ADDRESS________________________ CITY______________ STATE_____ ZIP________
(IF DIFFERENT)

PARENT/GUARDIAN #2________________________________ DOB______________

RELATIONSHIP TO PATIENT__________ EMPLOYER______________ OCCUPATION______________

HOME PHONE________________________ CELL PHONE________________________

WORK PHONE________________________ EMAIL________________________

ADDRESS________________________ CITY______________ STATE_____ ZIP________
(IF DIFFERENT)

Who carries the insurance for this patient? ____________________ DOB______ SSN____________

Is there secondary insurance for this patient? Y / N

If so, who carries the secondary? ________________________ DOB______ SSN____________

Preferred Pharmacy________________________ Location____________________

OTHER CHILDREN SEEN HERE

NAME__________________ DOB__________ / NAME__________________ DOB__________

NAME__________________ DOB__________ / NAME__________________ DOB__________

NAME__________________ DOB__________ / NAME__________________ DOB__________

NAME__________________ DOB__________ / NAME__________________ DOB__________

Your signature allows us to use electronic prescription verification.
I agree to pay the charges for the medical care for the above named child.
I authorize Health Care for Children to furnish my insurance company with medical records.
I authorize my insurance company to pay Health Care for Children directly.
I understand that my insurance policy is a contract between my insurance company and myself and that Health Care for Children files insurance as a courtesy.
I also understand that if my insurance company does not pay within 90 days, I will be billed.

Signature of Parent or Guardian________________________________ Date______________