Almouie Pedatircs, P.A.
PATIENT INFORMATION SHEET

PATIENT INFROMATION:

Name: (Last) _____ (First)_____(M.I.)_____

Street Address:_____ (Apt #)_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Social Security #:_____ Date of Birth:_____ Sex: F / M

Preferred Language:_____ Race:_____ Ethnicity:_____
Email:_____

PARENTS/GUARDIAN INFORMATION

Father's/Guardian Name:_____ DOB:_____ SS#:_____

Employer:_____ Work Phone:_____ Home Phone:_____

Mother's/Guardian Name:_____ DOB:_____ SS#:_____

Employer:_____ Work Phone:_____ Home Phone:_____

Religion:_____

Parent's Relationship: Married / Separated / Divorced / Living Together
Guardian's Relationship: Grandparent / Aunt/Uncle / Foster / Other:_____
Pharmacy:_____ Pharmacy Phone:_____

INSURANCE SUBSCRIBER

Policy Holder Name:_____ DOB:_____ Sex: M/F

SS#:_____ Relationship to patient:_____

Address:_____ Home phone:_____

City:_____ State:_____ Zip Code:_____

Employer:_____ Work Phone:_____

Emergency contact: Name of person not living with you:_____

Home phone:_____ Work Phone:_____ Relationship:_____

Effective 1/01/2020

I hereby authorize direct payment of medical benefits to Almouie Pediatrics, P.A. for service rendered. I understand that I am financially responsible for any balance not covered by my insurance and I hereby authorize Almouie Pediatrics to release my medical or incidental information that may be necessary for either medical or in processing applications for financial benefit. The signed authorization is good for the life of treatment with Almouie Pediatrics or until the patient reaches 21yrs of age.

Patient Name:_____ Date:_____

Parent Name:_____ Signature:_____