Anderson Hills PEDIATRICS

Patient Profile

PATIENT INFORMATION

Name: _____ **Patient ID #:** _____ **Sex:** [ ]M [ ]F

Address: _____ **Date of Birth:** _____

_____ **Primary Physician:** _____

City,State: _____ **Phone 1:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

☐ Patient address same as Bill To address. **Phone 2:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

PATIENT EMERGENCY CONTACTS

Name 1: _____ **Phone 1:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

Relationship: _____ **Phone 2:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

Name 2: _____ **Phone 1:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

Relationship: _____ **Phone 2:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

Name 3: _____ **Phone 1:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

Relationship: _____ **Phone 2:** _____ [ ]Home [ ]Work [ ]Cell [ ]Preferred

BILL TO:

Name: _____ **Phone 1:** _____

Address: _____ **Phone 2:** _____

_____ **Social Security #:** _____

City,State: _____ **Date of Birth:** _____

Marital Status: **Email Address:** _____

INSURANCE COVERAGE PRIMARY

☐ New Insurance

Ins Co Name: _____ **Patient's Insurance ID:** _____

Name of Insured: _____ **Policy Group:** _____

Insured Phone: _____ **Patient Relationship to Insured:** _____

Insured SS#: _____ **Copay Amount:** _____ **Effective Date:** _____

Insured Date of Birth: _____ **Employer:** _____

INSURANCE COVERAGE SECONDARY

Ins Co Name: _____ **Patient Insurance ID:** _____

Name of Insured: _____ **Policy Group:** _____

Insured Phone: _____ **Patient Relationship to Insured:** _____

Insured SS#: _____ **Copay Amount:** _____ **Effective Date:** _____

Insured Date of Birth: _____ **Employer:** _____

If you are new to the practice, how did you hear about us?

☐ Family ☐ Friend ☐ Phone Book ☐ Website ☐ OB/GYN

☐ Insurance Company Directory ☐ Other Physicians ☐ Hospital ☐ _____

I have received / declined (please circle one) a copy of AHP's Notice of Privacy Practices. _____ (initial please)

Signature: _____ **Relationship:** _____ **Date:** _____