CHILDREN FIRST, LLC
PEDIATRICS & ADOLESCENT MEDICINE

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Patient Information:

Name: Last_____ First _____MI_____
Patient's SS#: _____-_____-_____ Date of Birth_____ Gender_____
Street address_____ Apt.#_____
City_____ State_____ Zip_____

Mother / Legal Guardian Information

Name: Last_____ First _____MI_____
Street address_____ Apt.#_____
City_____ State_____ Zip_____
Phone: Home _____ Cell _____Work _____
Social Security **#:** _____-_____-_____ email address _____

Father / Legal Guardian Information

Name: Last_____ First _____MI_____
Street address_____ Apt.#_____
City_____ State_____ Zip_____
Phone: Home _____ Cell _____ Work _____
Social Security **#:** _____-_____-_____ email address _____

Primary Insurance Information:

Are you Self-pay? YES or NO
Does your child have Medicaid? YES or NO If Yes which MCO (Amerigroup, Priority Partners, MD Physician)
Does your child have Medicaid and Private Insurance? YES or NO
Does your child have Private Insurance? YES or NO
Insurance Name: _____
Subscriber Name _____ DOB: _____ SS#: _____
Relationship to patient: _____
Subscriber Number: _____ Group Number: _____

Secondary Insurance:

Insurance Name: _____
Subscriber Name _____ DOB: _____ SS#: _____
Relationship to patient: _____
Subscriber Number: _____ Group Number: _____

Other information:

List any allergies to food or drugs: _____

Person to contact in case of an emergency if unable to reach the parent/legal guardian listed above. Please list two people who are authorize to discuss your child's account information (medical history and account balance)

Name: _____ Phone:_____ Relationship to patient: _____
Name: _____ Phone:_____ Relationship to patient: _____

Parent / Legal Guardian Signature _____ ***Date*** _____