PRIMARY PEDIATRICS

PCP (Primary Care Provider) PLEASE CIRCLE ONE:

DR. SHEILA HARMELING **OR** DR. AMANDA DROPIC **OR** DR. MICHAEL FIEDLER **OR** MANDY RACE **OR** KRISTIE THELEN

PATIENT INFORMATION (LIST ALL CHILDREN WHO HAVE THE SAME RESPONSIBLE PARTY AND INSURANCE):

NAME: _____ DATE OF BIRTH: _____ SEX: MALE **OR** FEMALE

NAME: _____ DATE OF BIRTH: _____ SEX: MALE **OR** FEMALE

NAME: _____ DATE OF BIRTH: _____ SEX: MALE **OR** FEMALE

ADDRESS: _____CITY: _____STATE: _____ ZIPCODE: _____

HOME PHONE: _____ MOBILE PHONE: _____

PREFERRED MODE OF CONTACT FOR APPOINTMENT REMINDERS (PLEASE SELECT ONE ONLY):

AUTOMATED HOME PHONE CALL ( ) **OR** AUTOMATED CELL PHONE CALL ( ) **OR** TEXT MESSAGE ( )

RESPONSIBLE PARTY INFORMATION:

NAME: _____ DATE OF BIRTH: _____ SEX: MALE **OR** FEMALE

ADDRESS: _____ CITY: _____ STATE: ____ ZIPCODE: _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____

INSURANCE INFORMATION:

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____ SEX: MALE **OR** FEMALE

INSURANCE: _____ COPAY: _____ DEDUCTIBLE AMOUNT: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

MEMBER ID/ POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____

PARENT/ GUARDIAN INFORMATION:

MOTHER'S NAME: _____ OCCUPATION: _____MARITAL STATUS: _____

FATHER'S NAME: _____OCCUPATION: _____ MARITAL STATUS: _____

RACE: _____ETHNICITY: _____ PREFER NOT TO ANSWER _____

PRIMARY LANGUAGE: _____PREFER NOT TO ANSWER _____

TO ACCESS OUR ELECTRONIC PORTAL, GIVE US THE FOLLOWING INFORMATION OR STATE YES IF YOU ALREADY HAVE IT: _____

EMAIL: _____ ZIPCODE: _____

I HAVE READ AND UNDERSTAND THE HIPAA POLICY AND FINANCIAL POLICY: _____ DATE: _____