

# Brentwood East Pediatrics, L.L.C.

## PATIENT INFORMATION

NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

TELEPHONE \_\_\_\_\_ OTHER TELEPHONE \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MOTHER'S EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ MOTHER'S SOCIAL SEC. NO. \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

FATHER'S EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FATHER'S SOCIAL SEC. NO. \_\_\_\_\_

(CHECK ONE)

IS MOTHER OR FATHER THE PRIMARY INSURER? \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

PRIMARY INSURER GROUP NO. \_\_\_\_\_ ID NO. \_\_\_\_\_

SECONDARY INSURER GROUP NO. \_\_\_\_\_ ID NO. \_\_\_\_\_

CHILD'S SCHOOL NAME AND ADDRESS \_\_\_\_\_

PREFERRED PHARMACY NAME AND TELEPHONE \_\_\_\_\_

*As the parent of the above named child, please allow the following named individuals to present my child to your office for future medical care, if necessary. I understand that these individuals MUST bring a photo ID with them at the time of services.*

NAME \_\_\_\_\_ RELATION \_\_\_\_\_

NAME \_\_\_\_\_ RELATION \_\_\_\_\_

NAME \_\_\_\_\_ RELATION \_\_\_\_\_

I certify that the above information is correct and I hereby authorize payment to Brentwood East Pediatrics, LLC of any insurance payments due

Signature \_\_\_\_\_