PHYSICIANS AT SWEETWATER - *PEDIATRICS*
PATIENT INFORMATION RECORD

Date:

PATIENT INFORMATION

Patient Name: _____ Nickname: _____
Last Name First Name
Sex: ☐ Male ☐ Female Age: _____ Date of Birth: _____ Social Security # _____
Address: _____ City _____ State _____ Zip _____
Home Phone: _____ Alternate Phone: _____
Responsible Party: _____ Relationship to Patient: _____
Child's School: _____
Primary Care Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____
Drug Allergies: _____ Who referred you to our doctors?: _____
Emergency Contact: _____ Phone: _____

Parent's Marital Status (circle one) Married Divorced Single

MOTHER'S INFORMATION

Name: _____
Address: _____ City _____ State _____ Zip _____
Home Telephone #: _____ Work Telephone #: _____ Cell #: _____
Social Security # _____ Date of Birth: _____ Driver's License #: _____
Employed By: _____ Telephone #: _____
Work Address: _____ City _____ State _____ Zip _____

Is Mother's Coverage applicable to this child? Yes No

FATHER'S INFORMATION

Name: _____
Address: _____ City _____ State _____ Zip _____
Home Telephone #: _____ Work Telephone #: _____ Cell #: _____
Social Security # _____ Date of Birth: _____ Driver's License #: _____
Employed By: _____ Telephone #: _____
Work Address: _____ City _____ State _____ Zip _____

Is Father's Coverage applicable to this child? Yes No

ALL INSURANCE INFORMATION NEEDS TO BE COMPLETED.

Medicaid ☐ Yes ☐ No Recipient # _____
Star Medicaid ☐ Yes ☐ No Recipient # _____ Primary Care Physician _____

PRIMARY INSURANCE

Name of Insurance Company: _____ Copay $: _____
Insurance Company Address: _____ City _____ State _____ Zip _____
Name of Insured: _____ Social Security #: _____
Date of Birth: _____ Relationship to Patient: _____
Employer: _____ Group/Policy #: _____ ID #: _____
Effective Date: _____ Verification Telephone #: _____ Pre-certification Telephone: _____

SECONDARY INSURANCE

Name of Insurance Company: _____ Copay $: _____
Insurance Company Address: _____ City _____ State _____ Zip _____
Name of Insured: _____ Social Security #: _____
Date of Birth: _____ Relationship to Patient: _____
Employer: _____ Group/Policy #: _____ ID #: _____
Effective Date: _____ Verification Telephone #: _____ Pre-certification Telephone: _____

FOSTER CHILD/CPS INFORMATION

Custody of Child: ☐ CPS ☐ Adoption Agency ☐ Other _____
Case Worker Name: _____ Telephone #: _____