CHOC CHILDREN'S SPECIALIST - PATIENT INFORMATION FORM (CHILD)

(Please Fill-Out All Sections Completely And Accurately)

Today's Date: _____ **Appointment Date:** _____ **Time:** _____ **a.m./p.m.**

Referred to MD: _____ **Referring MD:** _____ **Telephone:** _____

Complaint/Dx: _____ **ICD9 Code:** _____

Patient's Last Name: _____ **First Name:** _____ **MI:** _____

Alert: _____ **MR#** _____ **AKA** _____

Address: _____ **Zip Code:** _____ **City:** _____ **State:** _____

Home Telephone Number: _____ **DOB:** _____ **Patient/Guarantor Relationship:** _____

Sex: _____ **Language:** _____ **Religion:** _____ **SSN:** _____ - _____ - _____ **Race** _____

Parent 1: _____**DOB:**_____ **Parent 2:** _____**DOB:**_____
Work #_____ **Work #:**_____
Cell #_____ **Cell #**_____
Email Address:_____ **Email Address:**_____

IN CASE OF EMERGENCY (Must Be Completed)

Emergency Contact Name: _____ **Day Telephone:** _____

Relationship to Patient: _____ **Home/Cell Telephone:** _____/_____

RESPONSIBLE PARTY (GUARANTOR)

Last Name: _____ **First Name:** _____

Address (if different) _____ **Zip Code:** _____

Home Telephone (if different) _____ **Work Telephone:** _____

DOB: _____ **Sex:** _____**SSN:** _____ - _____ - _____ **Employed By**: _____

Employer's Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ **IPA/Medical Group:** _____

Plan Type: **POS** **PPO** **HMO** **EPO**
Please circle correct plan type

Telephone: _____ **Fax**: _____

Claims Mail Address: _____ **Zip Code:** _____

City: _____ **State:** _____ **Subscriber #** _____

Subscriber: _____ **SSN:** _____ - _____ - _____ **DOB**:_____

Eligibility Date: _____ **Deductible/Share of Cost/Co-pay $**_____ **Group #** _____

PCP: _____ **Address:** _____

Zip Code: _____ **City:** _____ **State:** _____ **Telephone:** _____

Fax: _____ **Authorization #** _____ **Expiration:** _____

+ Please Turn Over And Complete Other Side!

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ **IPA/Medical Group:** _____

Telephone: _____ **Fax:** _____

Claims Mail Address: _____ **Zip Code:** _____

City: _____ **State:** _____ **Subscriber #** _____

Subscriber: _____ **SSN:** _____ - _____ - _____ **DOB**:_____

Eligibility Date: _____ **Deductible/Share of Cost/Co-pay $**_____ **Group #** _____

PCP: _____ **Address:** _____

Zip Code: _____ **City:** _____ **State:** _____ **Telephone:** _____

Fax: _____ **Authorization #** _____ **Expiration:** _____

Other Family Members Seen by Dr. Gillman or Dr. Ellis? **Yes** **No**

Name and Relationship_____

PLEASE BRING ANY X-RAYS OR LAB WORK RESULTS YOU HAVE THAT WOULD BE HELPFUL TO THE DOCTOR.