Uptown Pediatrics Patient Information Sheet

Date: ___________

Patient First Name: _______________________ Last Name: ____________________ DOB _____________

Name of hospital patient was born in: ______________________________ ( ) Male ( )female

If your child is a newborn, child's last name while in the hospital: ____________________________

How did you hear about us? ____

Did you have your prenatal visit with us? ( ) Yes ( ) No

Mother's Name ___________________________________ DOB: ____________________________

Father's Name _____________________________________ DOB: ____________________________

Patient's Home Address ____

Home Tel # __________________________ Email Address ______________________________

Patient lives with: ( ) Both Parents ( ) Mother ( ) Father ( ) Other______________________

Address if different from above: ____

Mom's Cell # ________________________________Dad's Cell # ______________________________

Mom's Work # _______________________________ Dad's Work # ____________________________

Emergency Contact (other than parents): ___________________________________

Emergency Contact #_________________________ Relationship to patient: ________________________

Please provide the telephone # to your regularly used Pharmacy: __________________________

Insurance Information

Primary Insurance Plan: ____

Policy #: __________________________________ Group # ________________________

Primary Policy Holders Name: ____________________________ DOB: ______________

Relationship to patient: _________________________ Employer________________________

____ ____

Name of Responsible Bill Payer (Guarantor)* Relationship to patient

____ ____

Signature of Responsible Bill Payer (Guarantor) Date

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD TO THE RECEPTIONIST AND *REFER TO OUR FINANCIAL POLICY FOR ADDITONAL INFORMATION