Kagan Pediatrics

Patient Information Sheet

Patient Information:

Children's Names: (first, middle, last)

____ Sex: ____ DOB: _____________ SS#: __________________

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Patient's(s') Address: ____

City/State/Zip: ____ **Home Phone:** ______________________________

Is it okay for our staff to leave you a voicemail regarding labs/medical information: ☐ Yes ☐ No

If yes, what is the best phone number to leave this information? ____

Does your child have health insurance? ☐ **Yes** ☐ **No If yes, who is the provider:** __________________________

How did you hear about us? ____

Parent/Guardian Information:

Mother's Name: ____ DOB: __________________________

SS#: ____ Driver's License #: ___________________________________

Address: ____ City/State/Zip: ________________________________

Home #: ________________________ Cell #: __________________________ Work #: ________________________

Employer: ____ Occupation: _____________________________

Father's Name: ____ DOB: __________________________

SS#: ____ Driver's License #: ___________________________________

Address: ____ City/State/Zip: ________________________________

Home #: ________________________ Cell #: __________________________ Work #: ________________________

Employer: ____ Occupation: _____________________________

Emergency Contact Information:

Name of person: ____ Phone #: ______________________________

Relationship to Patient(s): ____________________________________

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination of my child(ren) during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me.

Signature of
Responsible Party: ____ **Date**: _________________________