Pedsplus Urgent Care, LLC
Pedsplus Primary Care

Child (ren)s' information

Last Name_____First Name_____ MI: _____DOB: _____Gender_____

Last Name_____First Name _____MI: _____DOB:_____ Gender_____

Last Name_____Fist Name_____MI: _____DOB: _____Gender_____

Address: _____ City: _____ ZIP: _____

Ethicity_____Race_____PreferredLanguage_____

Mother's Last Name_____ First name _____ DOB_____

Gender_____Marital Status_____Cell Phone: _____Home Phone _____

Mother's Employer: _____Work Phone_____Occupation_____

Father's Last Name_____ First Name_____ DOB _____

Gender_____Marital Status_____Cell Phone:_____Home Phone_____

Father's Employer: _____Work Phone_____Occupation_____

Email: _____

RESPONSIBLE PARTY (The person responsible for the bill)**(Must be Completed by ALL-including Medicaid)**

Last Name_____First Name_____ DOB_____

Social Security Number: _____ Relationship to patient: _____

Address: _____ City: _____ Zip: _____

Work Phone : _____ Home phone: _____Cell Phone:_____

Occupation: _____ Employer: _____

Preferred Method of Communication: Home Phone_____Cell Phone_____Email_____

INSURANCE INFORMATION*(Policy's holder name, DOB and relationship must be completed, unless if Medicaid)*

Primary Insurance_____ Policy #: _____ Group #: _____

Policy Holder Name (*if Medicaid write self*)_____ Employer_____

Policy Holder DOB: _____**Relationship to Patient**: _____Effective Date_____ Co-Pay $_____

Secondary Insurance_____ Policy #: _____ Group #: _____

Parent/Guardian Signature_____Relationship to Patient_____

Name _____**Date** _____

How did you hear about us:_____ May we leave message in your phone: Yes_____ No _____

Pharmacy Name_____ Zip code or Phone # _____