OVIEDO CHILDREN'S HEALTH CENTER

Patient Information

Date: _____ How Did You Hear About Us? _____
Patient Name: Last _____ First_____ Middle _____
Date of Birth: _____/_____/_____ SS#: _____ / ___ /_____ SEX: MALE / FEMALE
Home Address: _____
City: _____ State: _____ Zip Code: _____
Preferred Telephone: (_____) _____- _____ Alternative Telephone: (_____) _____- _____
Race: _____ Ethnicity: _____ Preferred Language: _____
Email for Patient Portal: _____@_____
SIBLING INFORMATION *(who visit this office)*

NAME	Male / Female	DOB	SS#
	Male / Female		
	Male / Female		

PARENTS INFORMATION
Marital Status of Parents: [ ] Married [ ] Divorced or Divorce Pending [ ] Single *(Never Married)*
Mother's Name: _____Mom's Maiden Name: _____
Date of Birth: ____/_____/_____ SS#: _____ / ___ /_____ Cell Phone Number: (_____) _____- _____
Work Telephone: (_____) _____- _____ Alternative Telephone: (_____) _____- _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Employee:_____ Occupation: _____
Father's Name: _____
Date of Birth: ____/_____/_____ SS#: _____ / ___ /_____ Cell Phone Number: (_____) _____- _____
Work Telephone: (_____) _____- _____ Alternative Telephone: (_____) _____- _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Employee:_____ Occupation: _____

PRIMARY INSURANCE INFORMATION
Name of Insurance: _____ Effective Date: _____ / _____/ _____
Address for Claims: _____
Full Name of Insured**:** _____ Date of Birth: ____/_____/_____ SS#: ____ / ___ /_____
Employer: _____ Policy Type: [ ] HMO [ ] PPO [ ] PPC [ ] Other
ID Number: _____ Group Number: _____ Co-Pay Amount: $_____

GUARANTOR INFORMATION
Guarantor Name: _____ Relationship to Patient: _____
Guarantor Address: _____
Guarantor Email: _____@_____

PHARMACY INFORMATION
Name: _____ Location: _____
Telephone Number: (_____) _____- _____

EMERGENCY CONTACT - ***Must be different from Primary Telephone***
Emergency Contact Name: _____ Relationship to Patient:_____
Emergency Telephone: (_____) _____-_____

Financial Policy, Assignment Information, and Release of Information – I authorize the release of any information acquired in the course of treatment necessary to complete & file medical claims to my insurance company on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance to be paid directly to **Oviedo Children's Health Center** or its assignees. I am responsible for any non-covered services, supplies, co-payment, co-insurance or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This is acceptable & assignment will be in force for all future services by practitioners from this office.

_____ ___/___/____ _____ ___/___/____
Parent/Guardian Signature Date Witness Signature Date