Pediatric Intake Form

Patient Name: _____
First MI Last Suffix

Parent/Legal Guardian Name _____
First MI Last

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____
Street Apt # City State Zip

Home Phone: _____ Student Status: ☐ Full Time ☐ Part Time

Cell Phone: _____ ☐ Not a Student

Email: _____ School: _____

Parent / Legal Guardian Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Partner ☐ Divorced ☐ Other

Parent / Legal Guardian Spouse name (if applicable): _____

Emergency Contact: _____ Relationship to patient: _____

Contact phone number for Emergency contact: _____

Pediatrician/ Physician: _____ Location: _____

INSURANCE

Primary Insurance: _____ ID: _____ Group: _____ Plan: _____

Secondary Insurance: _____ ID: _____ Group: _____ Plan: _____

Patient's Relationship to Insured: ☐ Self ☐ Other _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Address: _____
Street Apt # City State Zip

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we would like to thank them. If you learned about or office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, a family member, or a friend, please provide their name. Thank You!

___ Physician
___ Audiologist
___ Website
___Other: _____
___Vocational Rehabilitation
___ Yellow Pages
___ Friend / Co-Worker
___ Social Media
___ Health Plan / HMO
___ Family Member
___ Hospital Referral
___ TV Commercial

*Please provide the name of the person that referred you to our clinic: _____