Patient's Primary Doctor: ________________________ **Phone Number:** ____________________

How did you hear about us? ____

Patient Information

Name: Last	First	Middle	Date of Birth	Gender
			____/____/______	M / F
			____/____/______	M / F
			____/____/______	M / F
			____/____/______	M / F

Parent/Guardian Information

Name: ______________________ DOB____________ SSN__________________ Gender M/F

Street Address/ Apt #: ____

City/ State/ Zip ______________________________ Patient's Primary Address? Y/ N

Contact: Primary Phone____________________ H/M/W Secondary ________________ H/M/W

Email Address______________________ would you like email updates? Y / N

Name: ______________________ DOB____________ SSN__________________ Gender M/F

Street Address/ Apt #: ____

City/ State/ Zip ______________________________ Patient's Primary Address? Y/ N

Contact: Primary Phone____________________ H/M/W Secondary ________________ H/M/W

Email Address______________________ would you like email updates? Y / N

Primary Insurance Information

Insurance Company ______________________

Subscriber (policy holder) ______________________

ID ______________________

Group______________________

Copay Amount______________________

Effective Date ______________________

Secondary Insurance Information

Insurance Company ______________________

Subscriber______________________

ID______________________

Group______________________

Copay Amount______________________

Effective Date______________________

Emergency Contact	Relationship to Patient	Phone Number

By signing below, I agree that I have filled this form out to my best ability and believe this information to be true and accurate. If any of the above information changes, I will notify Integrative Pediatrics LLC in writing.

____

Signature **Date**

____

Printed Name **Relationship to Patient**

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