PIONEER

Family Practice, PLLC 5130 Corporate Center CT SE, Lacey, WA 98503 Phone: 360-413-8600/Fax: 360-413-8822

CHILD PATIENT INFORMATION FORM

Last Name_____ ____ First name _____ MI_____ Male___ Female___

Date of birth_____/_____/_____ Social Security#_____ - ____ - _____ Student? Full _____ Part time _____

Home phone _____ Cell phone _____Email_____

Physical address_____Apt#_____

City _____ State _____ Zip code _____ - _____

Mailing address if different from above _____ Apt#_____

City _____State _____ Zip code _____ - _____

Race: Asian ___ Native Hawaiian ___ Black or African American___ White___ Hispanic___ Other race_____

Ethnicity: Hispanic _____ Not Hispanic _____ Language: English____ Spanish____ Other_____

CHILD'S primary care doctor _____ Referred by _____

Immediate family members _____

MOTHER'S NAME _____Date of birth _____/ ____/ _____

Social Security # _____ - _____ - _____ Driver's license # _____ State _____

Employer _____ Occupation _____Work phone (____) _____

Is mother a patient in this office? Yes ___ No ___ If yes, who is primary care doctor? _____

FATHER'S NAME _____ Date of birth _____/ ____/ _____

Social Security # _____ - _____ - _____ Driver's license # _____ State _____

Employer _____ Occupation _____Work phone (____) _____

Is father a patient in this office? Yes ___ No ___ If yes, who is primary care doctor? _____

Immediate family members _____

RESPONSIBLE PARTY INFORMATION

Name _____ Phone (____) _____Cell (____) _____

Date of birth _____/ ____/ _____ Social security # _____ - ____ - _____ Driver's license # _____State____

Mailing address _____

EMERGENCY CONTACT (please provide name of friend or relative not living with you that can be reached in case of an emergency)

Name _____ Phone (____) _____

Relationship to patient _____ Cell phone (____) _____

Address _____

INSURANCE INFORMATION (*we need current copy of card on file please)*

Insurance Co Name _____ Name of insured _____

Subscriber/member # _____ Group # _____ Co pay $ _____

Insured's address _____ Phone # (____) _____

(if different than above information)

Secondary insurance _____ Policy # _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS/CONTRACT

I hereby authorize Pioneer Family Practice to release to my primary and secondary insurance company any medical information necessary to process my insurance claim(s). My signature also authorizes any insurance benefits to be paid on my behalf to the providers at PFP. I hereby agree to full responsibility for all expenses incurred by myself or minor child. I understand that are billing fee/finance charge complying with Washington State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

MEDICARE PATIENTS ONLY: I understand my provider agrees to accept the Medicare allowed charge as the full charge and I am only responsible for the deductible, co-insurance and non-covered services.

Signature _____ Date _____/ _____ / _____

(Legal guardian must sign if patient is a minor)

Relationship to patient _____