



SENTARA

Medical Group
Pediatrics

Patient Information

Date
Account #

New Patient Update

PATIENT INFORMATION

Patient Name (Last)		(First)		(MI)	Social Security Number		
Home Address: Street				Apt. No.	City		
State	Zip Code	Home Phone ()		Birth Date		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary Doctor: _____		Are you currently taking 5 or more medications? <i>If yes, please request and complete a Patient Medication card.</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Siblings: <u>Name</u>		<u>DOB</u>		<u>Name</u>		<u>DOB</u>	
_____		_____		_____		_____	
_____		_____		_____		_____	
_____		_____		_____		_____	
How did you hear about SMG? <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Direct Mail <input type="checkbox"/> Physician Referral <input type="checkbox"/> Other							
Whom should we thank for your referral? _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Phone Book <input type="checkbox"/> Established							

PARENT / GUARANTOR

(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)

Patient's Relationship to Guarantor: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____							
Guarantor Name					Social Security Number		
Home Address: Street				City	State	Zip	Home Phone ()
Work Phone ()	Cell Phone ()	Alternate Phone ()		Would You Like to Receive Information by E-Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, E-Mail Address:</i>			
Employer Name and Address							
Other Parent					Social Security Number		
Employer Name and Address				Home Phone ()	Work Phone ()	Cell Phone ()	

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance ID No. (Member/Certificate)	Plan Name	Plan No.	Group No.
Subscriber Name <small>(The primary name in which the insurance policy is held)</small>			Effective Date
Social Security Number	Subscriber D.O.B.	Patient's Relationship to Subscriber <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____	

SECONDARY MEDICAL INSURANCE COMPANY

Insurance ID No. (Member/Certificate)	Plan Name	Plan No.	Group No.
Subscriber Name			Effective Date
Social Security Number	Subscriber D.O.B.	Patient's Relationship to Subscriber <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____	

IN CASE OF EMERGENCY, PLEASE CONTACT: (Local - other than parent)

Name	Relationship	Phone Number
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