SENTARA

Medical Group
Pediatrics

Patient Information

Date
Account #

n New Patient n 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 n Male n Female

Primary Doctor: ______________________

Are you currently taking 5 or more medications?
If yes, please request and complete a Patient Medication card. n Yes n No

Siblings:

Name	DOB	Name	DOB

How did you hear about SMG? n Newspaper n Friend n Radio n TV n Direct Mail n Physician Referral n Other

Whom should we thank for your referral? ______________________ n Insurance n Phone Book n Established

PARENT / GUARANTOR

(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)

Patient's Relationship to Guarantor: n Dependent Child n 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? n Yes n No	*If Yes, E-Mail Address:*
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 (The primary name in which the insurance policy is held)			Effective Date
Social Security Number	Subscriber D.O.B.	Patient's Relationship to Subscriber n Dependent Child n 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 n Dependent Child n Other ______________	

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

Name	Relationship	Phone Number

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