CHOC Children's
Primary Care Network

Patient Information Form

NOTE- If you have more than one child, please complete the family related information first. Copies will then be made to complete the information specific to each patient.

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Gender: ____ Male ____ Female Patient's Cell Phone: (____) _____ - _____

Ethnicity: ❑Hispanic or Latino ❑Non Hispanic or Latino ❑Unknown

Race: ❑American Indian ❑Asian ❑Black or African American ❑Native Hawaiian
❑Other ❑Other Pacific Islander Not Hawaiian Asian ❑Unknown ❑White

FAMILY INFORMATION BELOW

Home Address: _____
Street City State Zip

Primary: (____) _____ - _____ Secondary: (____) _____ - _____ Emergency Contact: _____ (____) _____-_____

I authorize the practice to leave detailed messages @ the #s listed above regarding my child's health, appointments, test results and billing unless otherwise specified here:

_____

Please circle one.
Mother/Father/Guardian: _____

Address (if different from patient's): _____

_____

Cell Phone: (____) _____ - _____

Email: _____

Employer: _____

Last 4 digits of SSN: _____ Birthday: ____/____/____

Please circle one.
Mother/Father/Guardian: _____

Address (if different from patient's): _____

_____

Cell Phone: (____) _____ - _____

Email: _____

Employer: _____

Last 4 digits of SSN: _____ Birthday: ____/____/____

Are parents of the child/children: ❑ Married ❑ Divorced ❑ Living Together ❑ Separated

IF PARENTS ARE DIVORCED OR SEPARATED, WHAT ARE THE LEGAL CUSTODY ARRANGEMENTS FOR THE CHILD/CHILDREN?

❑ Physical Custody – Name: _____ Relationship to Patient: _____

❑ Legal Custody: ❑ Sole ❑ Joint – Name(s): _____ Relationship to Patient: _____

***If sole legal custody, please provide legal documentation to be scanned into patient's chart.**

Caregiver Authorization: The following qualified relatives and/or caregivers have permission to seek care on behalf of my child, which includes immunizations, physical exams, testing and/or treatment for the purpose of medical diagnoses and medical care, which is deemed advisable and is to be rendered by the providers and staff.

*The Caregiver's Authorization Affidavit will remain in effect until further written notice.

Name/Relationship to Patient: _____ Name/Relationship to Patient: _____

Name/Relationship to Patient: _____ Name/Relationship to Patient: _____

Primary Insurance Information

Insurance Name: _____

Name of Subscriber: _____

ID #: _____

Group #: _____

Secondary Insurance Information

Insurance Name: _____

Name of Subscriber: _____

ID #: _____

Group #: _____

Sibling(s)'s Names/Date of Birth

_____ _____

_____ _____

Place
CHOC Patient Label
Here

I declare the information I provided above is correct and if there are any changes, I will notify the office immediately.

Name/Signature: _____ Date: _____