Horizon Pediatrics, Inc.

DATE:_____ OFFICE: _____ PRIMARY LANGUAGE SPOKEN:_____

PATIENT NAME:_____
(Last) (First) (Middle)

CHECK ONE: SEX: M_____ F_____ CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____

RACE: _____ ETHNICITY: _____ ADVANCED DIRECTIVES: YES ____ NO ____

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

RESPONSIBLE PARTY:_____RELATIONSHIP:_____ PHONE #:_____

PATIENT'S LOCAL ADDRESS:_____
(Street) (City) (Zip)

PERMANENT ADDRESS (IF DIFFERENT): _____

HOME TELEPHONE #: (_____) _____ CELL #: (____) _____ EMAIL:_____

EMPLOYED BY: _____ OCCUPATION:_____ WORK # (____) _____

BUSINESS ADDRESS: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE #: (____)_____

ALLERGIES TO MEDICATIONS:_____

PRIMARY PHARMACY: _____ PHONE #: (____)_____ LOCATION: _____

PRIMARY CARE PHYSICIAN: _____

REFERRED BY:_____ REASON FOR VISIT: _____

CHECK ONE: ILLNESS/INJURY RELATED TO: WORK ____ AUTO ____ OTHER ____ DATE OF INCIDENT: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY:_____ HMO_____ PPO _____ POS _____
(If applies, check)

POLICY/ID#_____ GROUP #_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

SECONDARY INSURANCE COMPANY NAME:_____

POLICY/ ID#_____ GROUP #_____

POLICY HOLDER:_____ RELATIONSHIP:_____ POLICY HOLDER'S DATE OF BIRTH:_____