

KERRY HENSLEY, M.D.-ERIK COX, M.D.

AVON PEDIATRICS

7376 BUSINESS CENTER DR, SUITE A – AVON, IN 46123

PH# 317-272-7887 – FAX# 317-353-3502

(Please Print)

PATIENT INFORMATION			
Patient's name:		Social Security no.:	DOB:
Address:	City:	State:	ZIP Code:
Home Phone: ()	Email:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Cell / Alt Phone: ()	Would you like to have access to your child's personal health record via the patient portal? <input type="checkbox"/> Y or <input type="checkbox"/> N (Email address and child's SSN required)		
Father/Guardian:	Work Phone: ()	SSN:	DOB:
Employer:	Does Father live in the home: Y or N		
Mother/Guardian:	Work Phone: ()	SSN:	DOB:
Employer:	Does Mother live in the home: Y or N		
ADDITIONAL INFORMATION (we are required to ask in accordance with the Affordable Care Act)			
Race:	Decline to specify <input type="checkbox"/>	Preferred Language:	
Ethnicity:	Options: Hispanic, Non-Hispanic, Decline to specify <input type="checkbox"/>		
INSURANCE INFORMATION			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ()
Name of primary insurance:		Phone: ()	
Subscriber's name:	DOB:	Employer: Employer phone no.: ()	Subscriber's relationship to the Patient:
Policy ID no.:		Group or Policy no.:	
Insurance Address:			
Name of secondary insurance (if applicable):		Phone: ()	
Subscriber's name:	DOB:	Employer: Employer phone no.: ()	Subscriber's relationship to the Patient:
Policy ID no.:		Group or Policy no.:	
Insurance Address:			

Patient's name:	DOB:
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OTHER SIBLINGS		
Name:	DOB:	Social Security #:
Name:	DOB:	Social Security #:
Name:	DOB:	Social Security #:
Name:	DOB:	Social Security #:

EMERGENCY CONTACTS	
Primary Contact Name:	Relationship to patient:
Home Phone:	Email:
Work Phone:	EXT#:
Other phone:	

Secondary Contact Name:	Relationship to patient:
Home Phone:	Email:
Work Phone:	EXT#:
Other phone:	

How did you hear about our office?	Referring Doctor:	Phone:
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Date:	Signature:
Completed by (print):	Relationship to the patient: