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: ( ) Cell / Alt Phone: ( )	Email: Would you like to have access to your child's personal health record via the patient portal? ❑ Y or ❑ N	Gender: ❑ M ❑ F

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 ❑ Preferred Language:

Ethnicity: Options: Hispanic, Non-Hispanic, Decline to specify ❑

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:

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:

Date:	Signature:
Completed by (print):	Relationship to the patient: