

# Countryside Pediatric Care

**Patient Name** (Last, First, MI) \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: M F Referred by \_\_\_\_\_

**Guardian / Parent # 1** ( Mother / Stepmother) Check One Guarantor Y N

Name (Last, First, MI) \_\_\_\_\_ SS# \_\_\_\_\_ Hm. Ph. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: M F Email \_\_\_\_\_ Wk. Ph. \_\_\_\_\_

Employer \_\_\_\_\_ Cell ph. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

**Guardian / Parent # 2** ( Father / Stepfather) Check One Guarantor Y N

Name (Last, First, MI) \_\_\_\_\_ SS# \_\_\_\_\_ Hm. Ph. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: M F Email \_\_\_\_\_ Wk. Ph. \_\_\_\_\_

Employer \_\_\_\_\_ Cell ph. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

**Guardian / Parent # 3** ( Other \_\_\_\_\_ ) Check One Guarantor Y N

Name (Last, First, MI) \_\_\_\_\_ SS# \_\_\_\_\_ Hm. Ph. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: M F Email \_\_\_\_\_ Wk. Ph. \_\_\_\_\_

Employer \_\_\_\_\_ Cell ph. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

## Insurance Company

Name \_\_\_\_\_ Plan Name \_\_\_\_\_

Policy Holder / Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Co Pay \_\_\_\_\_ Insurance Effective Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Signed

Relationship if other than patient \_\_\_\_\_