



# SCHOOLHOUSE PEDIATRICS

## 2019 Personal Information Update

Please PRINT Completely and Clearly

**Patient's Name(s) ALL CHILDREN:** \_\_\_\_\_

**DOB(s):** \_\_\_\_\_

**Gender: M or F** \_\_\_\_\_ **Language:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**PREFERRED Phone # for \*APPT REMINDER CALLS:** \_\_\_\_\_

**Email FOR \*REMINDER EMAIL\*:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

*Address same as above check here:*

**Mother's Mailing Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

*Address same as above check here:*

**Father's Mailing Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

### **Insurance Information**

**Primary Insurance:** \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

### **Pharmacy**

**Pharmacy Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

- **Co-payments MUST be made at the time of the visit or a \$10.00 surcharge will be added – Since 2007.**
- **No Show Policy effective 1/1/2019: 24 hr notice for cancellation or a \$25.00 surcharge will be added to balance that is not covered by insurance.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_