

Date ____/____/____

Evergreen Children's Clinic Patient information

PLEASE PRINT

PATIENT NAME: _____ BIRTH DATE: ____/____/____ SEX: M F
FIRST MI LAST

SOCIAL SECURITY # OF PATIENT: _____

PATIENT'S ETHNICITY PLEASE SELECT: PATIENT'S RACE _____ PREFERRED WRITTEN LANGUAGE _____ PREFERRED SPOKEN LANGUAGE _____

- African American Jewish
- Hispanic/Latino Mediterranean
- Pacific Islander Multi-Racial
- American Indian Caucasian
- Non-Hispanic Eskimo
- Other Middle Eastern
- Asian

Parent E-Mail address _____
(Optional)

ADDRESS: _____ CITY: _____ ST: _____ ZI:P _____

HOME PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____ mom cell dad cell other cell (list) _____

Emergency contact name and relation to patient: _____ Phone Number: (____) _____ - _____

GUARANTOR INFORMATION(PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE)

NAME: _____ BIRTH DATE: ____/____/____ SEX: M F
FIRST MI LAST

SS# ____/____/____ GUARANTOR'S RELATIONSHIP TO PATIENT _____ PHONE: (____) _____ - _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

EMPLOYER NAME _____ PHONE NUMBER: (____) _____ - _____

PATIENT INSURANCE INFORMATION ** PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD (S) **

	Primary Insurance	Secondary Insurance
Insurance Provider:		
Subscriber's Name:		
Subscriber's birth date:		
Subscriber's Employer:		
Subscriber's Insurance ID:		
Group #:		
Co-pay		

Mother's Name: _____ SS# ____/____/____
First M.I. Last

Date of birth ____/____/____ ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

Phone: (____) _____ - _____ Additional Phone: (____) _____ - _____

Employer: _____ Phone: (____) _____ - _____

Father's Name: _____ SS# ____/____/____
First M.I. Last

Date of birth ____/____/____ ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

Phone: (____) _____ - _____ Additional Phone: (____) _____ - _____

Employer: _____ Phone: (____) _____ - _____