



HEALTHY STEPS PEDIATRICS

Helping to GROW healthy children one step at a time



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PATIENT DEMOGRAPHIC INFORMATION

Today's Date: _____

Name of Person Filling Out Form: _____

Relation to Patient: _____

Patient Name: _____
Last First Middle Nickname

Street Address: _____

City State Zip Code County

Primary Number: (____) _____ Home ___ Work ___ Cell ___ Other ___
Secondary Number: (____) _____ Home ___ Work ___ Cell ___ Other ___

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Mother's maiden name? _____ How did you hear about us? _____

Please list all siblings including DOB and age: _____

RESPONSIBLE PARTY INFORMATION *The adult that brings in the child is responsible for any fees at the time of service.*

Parent/Legal Guardian 1:

Name: _____
Relation to Patient: _____
Home Phone: _____
Employer: _____
Work Phone: _____
Cell Phone: _____
Email: _____
DOB: _____
Driver's License #: _____ State: _____

Parent/Legal Guardian 2:

Name: _____
Relation to Patient: _____
Home Phone: _____
Employer: _____
Work Phone: _____
Cell Phone: _____
Email: _____
DOB: _____
Driver's License #: _____ State: _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company : _____
Member ID Number: _____
Group Number: _____
Cardholder/Subscriber's Name: _____
Subscriber DOB: _____

Secondary Insurance:

Insurance Company : _____
Member ID Number: _____
Group Number: _____
Cardholder/Subscriber's Name: _____
Subscriber DOB: _____

EMERGENCY CONTACT *(other than parents)*

Name: _____ Relation to Patient: _____

Phone # _____ Home ___ Work ___ Email address: _____
Cell ___ Other ___

PHARMACY INFORMATION

Name: _____ Address: _____ Phone #: _____

CONSENT FOR MEDICAL CARE AND ASSIGNMENT OF BENEFITS

I authorize *Healthy Steps Pediatrics, LLC* to provide medical care for my child/children. I authorize payment of medical benefits directly to *Healthy Steps Pediatrics, LLC* for services provided. I authorize provider to release any medical information required to process my claims.

Signature: _____ Print Name: _____ Date: _____