# ADVANCED PEDIATRICS

3712 Winter Garden Vineland Rd.
Winter Garden, FL 34787
Tel.: (407) 656-2229
Fax: (407) 656-0998

## PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: (____) _____ M/F _____ Social Security #: _____
MOTHER'S NAME: _____ SS #: _____ CELL PH.: (____) _____
ADDRESS AND PHONE (if different) _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____
FATHER'S NAME: _____ SS #: _____ CELL PH.: (____) _____
ADDRESS AND PHONE (if different) _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ WORK PHONE: (____) _____ EXT: _____
REFERRED BY: _____ PHONE: (____) _____

**IN CASE OF EMERGENCY**
CLOSEST RELATIVE NOT LIVING WITH YOU: _____ PHONE: (____) _____

## PERSON RESPONSIBLE FOR BILL

LEGAL NAME: _____ RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
DRIVER LICENSE #: _____ STATE ISSUED: _____
ADDRESS: _____
MAILING ADDRESS (if different): _____
PHONE: HOME (____) _____ WORK (____) _____ CELL (____) _____
E-MAIL ADDRESS: _____ EMPLOYER: _____

## INSURANCE COMPANY INFORMATION

Insurance: _____ I.D. #_____ Group Name or #_____
Address: _____ Phone: (____) _____
Policy Holder's Name: _____ Date of Birth: _____

Secondary Insurance: _____ I.D. #_____ Group Name or #_____
Address: _____ Phone: (____) _____
Policy Holder's Name: _____ Date of Birth: _____

## PLEASE ANSWER THE FOLLOWING

Have you or anyone in your immediate family been a patient in our office before?____ yes ____ no. If yes, please list:
Name: _____ Relationship: _____ When? _____
Has your child been seen in the hospital by our physicians?_____ yes _____ no.