LOUISVILLE PEDIATRIC SPECIALISTS, PC.

New Patient Questionnaire

(To be filled out by parent or legal guardian)

Last Name:		Social Security No::	
First Name:	Mid. Initial:	Date of Birth:	
Home Address:		Age:	Sex:
Home Address2:		Home Phone:	
City, State, Zip:		Cell Phone:	
Patient Email Address:			
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally separated ☐Unknown			
Race: ☐Caucasian ☐Hispanic ☐Black / African American ☐Asian ☐Native American ☐Other Race ☐More than 1 Race			
Ethnicity: ☐Latino/Hispanic ☐Other ☐Not Reported/Refused ☐English ☐American			
Language: ☐English ☐Other – Please list:			
Referred ☐Mother ☐Guardian by:		Referring by tel:	
PARENTS INFORMATION			
Name:		☐Mother ☐Stepmother ☐Guardian	
Employer Name:		Work Tel:	
EMGERGENCY CONTACT / PHARMACY INFORMATION:			
Name:		Contact Tel:	
Preferred Pharmacy:		Pharmacy Tel:	
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING PERSON(S):			
I authorize the release of medical information to my spouse and/or next of kin:			
Name:	Relationship:	Tel:	
Name:	Relationship:	Tel:	
The office staff may leave messages on my answering machine or voice mail ☐Yes / ☐No			
PRIMARY INSURANCE			
Plan Name:		Group #:	
Plan Tel:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy #	
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other			
SECONDARY INSURANCE			
Plan Name:		Group No.:	
Plan Tel:		Subscriber DOB:	
Subscriber Name:		Subscriber ID/Policy No:	
Relationship to Patient: ☐Self ☐Wife ☐Husband ☐Parent ☐Other			
Assignment of Insurance Benefits			

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New Patient Questionnaire
(To be filled out by parent or legal guardian)

I authorize payment of medical benefits to: LOUISVILLE PEDIATRIC SPECIALISTS for services rendered. I also authorize the release of any medical information necessary to process my insurance claims. I request and authorize that payment/insurance benefits be made directly to LOUISVILLE PEDIATRIC SPECIALISTSany services furnished to the above named patient by LOUISVILLE PEDIATRIC SPECIALISTS The signature below shall suffice for all insurance forms on a continuing basis. I understand I can change the authorization information anytime in writing.

Patient or authorized persons signature: _____ Date: _____