Children's Health Partners, SC

Today's date:___/___/____ Patient Information Form

Patient Information:

Patient's Name (Last) _____ (First)_____(Middle)_____

Birthdate: _____ Sex: O Male O Female

Home Address: _____ City: _____ Zip: _____

County: _____ Subdivision Name: _____

Primary Phone: _____ Name of school: (if attends) _____

Siblings:

Name:	Birthdate:

Parent/Guardian Information:

Name: (Last)_____(First)_____(MI)___

Birth date: _____

Complete Address (If different than patient):

_____

Primary Phone: _____

Work Phone: _____

Cell Phone: _____

Profession/Job Title: _____

Employer: _____

Social Security #: _____

Name: (Last)_____(First)_____(MI)___

Birth date: _____

Complete Address (If different than patient):

_____

Primary Phone: _____

Work Phone: _____

Cell Phone: _____

Profession/Job Title: _____

Employer: _____

Social Security #: _____

*If other adults will be seeking medical care for your child/children, please complete Permission to Seek Treatment Form

Insurance Information:

Insurance Company: _____

Policy Holder / Guarantor: _____

ID Number: _____ Group Number: _____

How did you hear about Children's Health Partners?

- O Physician _____
- O Friend _____
- O Edward Hospital Physician Referral Service
- O Cradle Talk
- O Other _____

IN CASE OF EMERGENCY:
Person/s other than listed above:

_____

Relationship _____

Phone #1: ___-___-____ Phone #2:___-___-____

Revised Date 4/11/17