Children's Health Partners, SC

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

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

Birthdate: _____ Sex: O Male O Female

Home Address: _____City:_____Zip:_____

County: _____ Subdivision Name: _____

Name of school:

Primary Phone: _____ (if attends) _____

Siblings:

Name:	Birthdate:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Guardian Information:

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

Birth date: _____

Complete Address (If different than patient):

_____

Work Phone: _____

Cell Phone: _____

Profession/Job Title: _____

Employer: _____

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

Birth date: _____

Complete Address (If different than patient):

_____

Work Phone: _____

Cell Phone: _____

Profession/Job Title: _____

Employer: _____

Please provide preferred contact information for the purpose of NON-CLINICAL communications (i.e. electronic appointment reminders.)

Primary Email: _____ **Cellphone No. for Text Messages:**_____

*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: _____Social Security # (last 4 digits):_____

ID Number: _____ Group Number: _____

How did you hear about Children's Health Partners?

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

_____
Parent/ Legal Custodian Signature

IN CASE OF EMERGENCY:
Person/s other than listed above:
_____
Relationship _____
Phone #1: ____-____-_____ Phone #2:____-____-_____