PEDIATRIC ASSOCIATES AT ARGYLE, P.A.

DM HealthNet: Patient Information Form - Revised March 2019

DT ENTD:	INITIALS:
	ACCT #

Section A: PATIENT INFORMATION TODAY'S DATE _____

NAME _____
Last First Middle

DATE OF BIRTH ____/____/____ SOCIAL SECURITY NUMBER ____/____/____ SEX ☐ Male ☐ Female MARITAL STATUS _____

ADDRESS _____
Street Number Apt. # City ZIPCODE

HOME PHONE (___) _____ WORK PHONE (_____) _____ EXT. _____ MOBILE/CELL PHONE _____

PREFERRED LANGUAGE _____ ETHNICITY/RACE _____ EMAIL _____

EMPLOYER/SCHOOL NAME _____ EMERGENCY CONTACT/ADDRESS/TEL.NO. _____

PREFERRED PHARMACY (Tel and Address) _____

Section B: LEGAL STATUS

Person accompanying patient should indicate your relationship to patient. Legal documents and picture I.D. will be required to show proof of identity. Please check one and complete information below.

O Parent O Legal Guardian O Other _____

NAME _____
Last First Middle

DATE OF BIRTH ____/____/____ SOCIAL SECURITY NUMBER ____/____/____ SEX ☐ Male ☐ Female MARITAL STATUS _____

ADDRESS (If different from patient) _____

HOME PHONE (___) _____ WORK PHONE (_____) _____ EXT. _____ MOBILE/CELL PHONE _____
EMPLOYER/SCHOOL NAME _____ FULL TIME?

Section C: INSURANCE INFORMATION Present picture ID and insurance cards to the Front Office for copying.

IMPORTANT: Provide OTHER HEALTH INSURANCE (Secondary) information as applicable. Non-disclosure of information is insurance fraud. In the event that you or your dependent(s) are found not eligible for coverage, you will be responsible for payment of rendered services.

PRIMARY: ☐ NONE ☐ MEDICAID ☐ OTHER
NAME OF INSURANCE _____ INSURANCE ADDRESS _____
PHONE (___) _____ CONTACT PERSON _____
POLICY NO. _____ GROUP # OR NAME _____ EFFECTIVE DATE _____
NAME OF INSURED _____ INSURED'S SOCIAL SECURITY NO. _____
INSURED'S DATE OF BIRTH _____
PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Wife ☐ Husband ☐ Child ☐ Other (Specify) _____
INSURED'S ADDRESS (if different from patient) _____

SECONDARY: ☐ NONE ☐ MEDICAID ☐ OTHER
NAME OF INSURANCE _____ INSURANCE ADDRESS _____
PHONE (___) _____ CONTACT PERSON _____
POLICY NO. _____ GROUP # OR NAME _____ EFFECTIVE DATE _____
NAME OF INSURED _____ INSURED'S DATE OF BIRTH _____
PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Wife ☐ Husband ☐ Child ☐ Other (Specify) _____
INSURED'S ADDRESS (if different from patient) _____

PRIMARY CARE PHYSICIAN: _____
REFERRING PHYSICIAN (If different from Primary Care Physician) _____