

**Shoreline Pediatrics and Adolescent Medicine, P.C**  
**Patient Information Form**

Account # \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Last First Middle

Mother's Name: \_\_\_\_\_  
Street Town State Zip Code

Home Phone: \_\_\_\_\_

Dad's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Mom's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Phone : \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Copay: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_ Previous records requested: \_\_\_\_\_

Dependent Children (Include last name if different)

<u>Name:</u>	<u>Sex:</u>	<u>Date of birth:</u>	<u>Ins. ID#</u>
1. _____	M-F	_____ - _____ - _____	_____
2. _____	M-F	_____ - _____ - _____	_____
3. _____	M-F	_____ - _____ - _____	_____
4. _____	M-F	_____ - _____ - _____	_____

**Release of Information:** *I authorize the release of any medical information required from my insurance company, or from medical & school personnel, regarding the care of dependent children listed above.*

**Financial Agreement:** *I understand that all fees for services not covered by managed care contracts are due & payable at the time of visit. This includes all insurance copays. If legal action is required to collect these fees, I agree to pay all collection costs.*

Signature: \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_