NW PEDIATRICS

INTEGRATIVE MEDICINE

Preferred Language: _____

Patient Information

Name: Last First Middle Date of Birth Gender Identity
_____ ____/____/_____ M◯F◯Other___

Authorization to Provide Allergies & Medication List to Pharmacy: Y◉N◯ ALERT IIIS Consent: Y◯N◯

Parent/Guardian Information

Name: _____ DOB_____ Identity: M◯F◯Other_____
Street Address/ Apt #: _____
City/ State/ Zip _____Patient's Primary Address? Y◯N◯
Primary Phone_____ ok to leave confidential voicemail? Y◯ N◯ ok to text? Y◯N◯
Secondary Phone _____ ok to leave confidential voicemail? Y◯N◯ ok to text? Y◯N◯
Email Address_____ Social Security Number: _____

Name: _____ DOB_____ Identity: M◯F◯Other_____
Street Address/ Apt #: _____
City/ State/ Zip _____Patient's Primary Address? Y◯N◯
Primary Phone_____ ok to leave confidential voicemail? Y◯ N◯ ok to text? Y◯N◯
Secondary Phone _____ ok to leave confidential voicemail? Y◯N◯ ok to text?Y◯N◯
Email Address_____ Social Security Number: _____

Insurance & Financial Information: ***Please contact your insurance company directly to complete this section***

Primary Insurance

Insurance Company: _____
Plan: _____
ID#: _____
Group#: _____
Subscriber (policy holder):
_____
Subscriber DOB: _____
Copay Amount: _____
Coinsurance Amount: _____
Deductible Applies? Y◯ N◯
Deductible amount? _____
Effective Date? _____

Secondary Insurance

Insurance Company: _____
Plan: _____
ID#: _____
Group#: _____
Subscriber (policy holder):
_____
Subscriber DOB: _____
Copay Amount: _____
Coinsurance Amount: _____
Deductible Applies? Y◯ N◯
Deductible amount? _____
Effective Date? _____

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Emergency Contact **(Adult outside of family residence)**	Relationship to Patient	Phone Number

How did you hear about us? _____

Why did you choose our clinic? _____

_____

By signing below, I agree that I have filled out this form to the best of my ability, and I believe this information to be true and accurate. If any of the above information changes, I will notify NW Pediatrics Integrative Medicine in writing.

Signature	Date
Printed Name	Relationship to Patient

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