LeBlanc PEDIATRICS

PATIENT'S INFORMATION

Last Name:	First: Preferred name:	Middle Name:
Street Address:		
City:	State:	Zip:
Date of Birth:	Soc. Sec. No.:	Gender:
Email Address for MyChart:		

MOTHER'S INFORMATION

Last Name:	First:	Middle Name:
Street Address:		
City:	State:	Zip:
Date of Birth:	Social Sec No.:	Employer:
Home Phone:	Work:	Cell:
□ Single □ Married □ Divorced □ Separated □ Widowed	Language: □ English □ Spanish □ Other	

FATHER'S INFORMATION

Last Name:	First:	Middle Name:
Street Address:		
City:	State:	Zip:
Date of Birth:	Social Sec No.:	Employer:
Home Phone:	Work:	Cell:
□ Single □ Married □ Divorced □ Separated □ Widowed	Language : □ English □ Spanish □ Other	

ADDITIONAL CHILDREN'S INFORMATION THAT WILL BE TRANSFERRING TO LEBLANC PEDIATRICS

Last Name(1):	First:	Middle Name:
□ Male □ Female	Date of Birth:	SSN:
Last Name(2):	First:	Middle Name:
□ Male □ Female	Date of Birth:	SSN:
Last Name(3):	First:	Middle Name:
□ Male □ Female	Date of Birth:	SSN:
Last Name(4):	First:	Middle Name:
□ Male □ Female	Date of Birth:	SSN:

INSURANCE INFORMATION

Insurance Company (1):	Policy No.:	
Name of Insured:	Date of Birth:	Contact # for Ins:
Insurance Company(2):	Policy No.:	
Name of Insured:	Date of Birth:	Contact # for Ins:
Is child insured by Medicaid: □ Yes □No	Medicaid Policy Name:	
Medicaid Policy No.:		

EMERGENCY CONTACT

Name:	Relationship to Patient:
Primary Phone:	Secondary Contact No.:

Please read, sign and date

I authorize LeBlanc Pediatrics to bill my insurance company for charges incurred. I authorize LeBlanc Pediatrics to release medical information requested by the insurance company with regard to claims filed on behalf of the children listed above. I understand that I will be responsible for charges denied or not covered by my insurance company. This includes co-payments not paid at the time of service.

Signature **X**	**Date**