CHOC Children's
Primary Care Network

Patient Information Form

FOR OFFICE USE ONLY: MRN # _____

Pt. Name_____ DOB _____

NOTE- If you have more than one child, please complete the family related information first.

Copies will then be made to complete the information specific to each patient.

First Name:_____ Last Name:_____ Middle Initial: _____

Date of Birth:_____/_____/_____ Gender:_____Male_____Female Patient's Cell Phone: (_ _)_____- _____

Ethnicity: _____Hispanic or Latino_____Non Hispanic or Latino_____Unknown

Race: _____American Indian_____Asian_____Black or African American_____Native Hawaiian

_____Other_____Other Pacific Islander Not Hawaiian Asian_____Unknown_____White

FAMILY INFORMATION BELOW

Home Address: _____

Street City State Zip

Primary: (_ _)_____-_____Secondary: (____)_____-_____Emergency Contact:_____(____)_____-_____

I authorize the practice to leave detailed messages @ the #s listed above regarding my child's health, appointments, test results and billing unless otherwise specified here:

Please circle one.
Mother/Father/Guardian: _____

Address (if different from patient's): _____

Cell Phone: (_ __) _____ - _____

Email: _____

Employer: _____

Last 4 digits of SSN: _____ Birthday: ____/_ __/____

Please circle one.
Mother/Father/Guardian: _____

Address (if different from patient's): _____

Cell Phone: (_ __) _____ - _____

Email: _____

Employer: _____

Last 4 digits of SSN: _____ Birthday: __/____/_ ___

Are parents of the child/children: ☐ Married ☐ Divorced ☐ Living Together ☐ Separated

IF PARENTS ARE DIVORCED OR SEPARATED, WHAT ARE THE LEGAL CUSTODY ARRANGEMENTS FOR THE CHILD/CHILDREN?

☐ Physical Custody – Name:_____Relationship to Patient: _____

☐ Legal Custody: ☐ Sole ☐ Joint – Name(s):_____Relationship to Patient: _____

***If sole legal custody, please provide legal documentation to be scanned into patient's chart.**

Caregiver Authorization: The following qualified relatives and/or caregivers have permission to seek care on behalf of my child, which includes immunizations, physical exams, testing and/or treatment for the purpose of medical diagnoses and medical care, which is deemed advisable and is to be rendered by the providers and staff.

*The Caregiver's Authorization Affidavit will remain in effect until further written notice.

Name/Relationship to Patient:_____Name/Relationship to Patient: _____

Name/Relationship to Patient:_____Name/Relationship to Patient: _____

Primary Insurance Information

Insurance Name: ____

Name of Subscriber: _

ID #: _____

Group #: _____

Secondary Insurance Information

Insurance Name: ____

Name of Subscriber: _

ID #: _____

Group #: _____

I declare the information I provided above is correct and if there are any changes, I will notify office immediately.

Name/Signature:_____Date: _____