CHERRY CREEK PEDIATRICS
Patient Information Form

PATIENT NAME:____Today's Date__________________________
Last First Middle

DOB:______________________Sex: Female Male Patient Cell Number (if applicable)____________________

RACE: (Choose One): American Indian/Alaska Native Asian Black/African American
More Than One Race Native Hawaiian/Other Pacific Islander White Declined to Answer

ETHNCITY (Choose One): Hispanic or Latino Not Hispanic or Latino Declined to Answer

MOTHER/PARENT 1

Name:____
Last First MI

Date of Birth:_________Soc Sec #__________________
Home Address:________________________________
City:________________State:_________Zip:________

Check Primary Phone Number
Home Phone Number: ______________________
Cell Phone Number:_______________________
Work Phone Number: _____________________

Employer:____
Occupation:_______________________________________

FATHER/PARENT 2

Name:____
Last First MI

Date of Birth:__________Soc Sec #___________________
Home Address:_________________________________
City:_______________State:_________Zip:___________

Check Primary Phone Number
Home Phone Number: __________________________
Cell Phone Number: ___________________________
Work Phone Number_____________________________

Employer:____________________________________
Occupation:__________________________________

Emergency Contact:______________________________Relationship:___________Phone #:______________________

Parents are: Married Divorced Other Child(ren) live(s) with Mom Dad Both

Explain Other:____

Written Language of Family:_____________________Spoken Language of Family:______________________________

Insurance: ______________________________________ Insured's Name: _________________________________
Insurance ID Number: _____________________________ Group Number: __________________________________

Responsible Party:____________________________________

The information provided above is complete and accurate to the best of my knowledge. I acknowledge that I have received Cherry Creek Pediatrics' Notice of Privacy Practices. I have read, fully understand, and agree to all terms set forth in the Financial Policy of Cherry Creek Pediatrics, PC. I assign directly to Cherry Creek Pediatrics all insurance benefits if any, otherwise payable to me for services rendered. I understand that some or all of the services provided may not be covered by insurance for which I may also be billed. I hereby authorize Cherry Creek Pediatrics to release all information necessary for claims administration and evaluation, utilization review and financial audit. I authorize my child to be treated without me being in attendance.

Signature:____Date: ____

Over 18 years Patient Signature:__________________________________Date: ____

CHERRY CREEK PEDIATRICS
Patient Information Form (continued)

SIBLING 1 NAME:____
Last First Middle

DOB:______________________Sex: F M Patient Cell Number (if applicable) ___________________

RACE: (Choose One): American Indian/Alaska Native Asian Black/African American
More Than One Race Native Hawaiian/Other Pacific Islander White Declined to Answer

ETHNCITY (Choose One): Hispanic or Latino Not Hispanic or Latino Declined to Answer

SIBLING 2 NAME:____
Last First Middle

DOB:______________________Sex: F M Patient Cell Number (if applicable)___________________

RACE: (Choose One): American Indian/Alaska Native Asian Black/African American
More Than One Race Native Hawaiian/Other Pacific Islander White Declined to Answer

ETHNCITY (Choose One): Hispanic or Latino Not Hispanic or Latino Declined to Answer

SIBLING 3 NAME:____
Last First Middle

DOB:______________________Sex: F M Patient Cell Number (if applicable)___________________

RACE: (Choose One): American Indian/Alaska Native Asian Black/African American
More Than One Race Native Hawaiian/Other Pacific Islander White Declined to Answer

ETHNCITY (Choose One): Hispanic or Latino Not Hispanic or Latino Declined to Answer