MERIDIAN PEDIATRICS PATIENT INFORMATION

PATIENT NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE ZIP _____

SS# _____ SEX: M F_ PHONE ( ) _____ CELL # _____

EMERGENCY CONTACT & NUMBER _____

FAMILY INFORMATION

MOTHER	FATHER
BIRTHDATE	BIRTHDATE
ADDRESS	ADDRESS
PHONE WORK	PHONE WORK
SS#	SS#
HEALTH ISSUES:	HEALTH ISSUES:

FAMILY- BROTHERS & SISTERS	AGE	NAME (FULL NAME IF DIFFERENT)	HEALTH ISSUES
SIBLING M F			
SIBLING M F			
SIBLING M F			
SIBLING M F			

BILLING INFORMATION

PRIMARY INSURANCE COMPANY _____ EMPLOYER _____
POLICY HOLDER NAME _____ DOB: _____
ID # _____ GROUP # _____
ADDRESS (IF DIFFERENT THAN ABOVE) _____
SECONDARY INSURANCE COMPNAY _____ EMPLOYER
POLICY HOLDER NAME _____ DOB: _____
ID It _____ GROUP # _____
ADDRESS (IF DIFFERENT THAN ABOVE) _____
PATIENTS MEDICAID NUMBER

I authorize the Doctors and Staff of Meridian Pediatrics to provide medical treatment for my child. I further authorize the release of any medical information necessary to process my insurance claims. Also, I request that payment from the insurance company be made directly to Meridian Pediatrics. I acknowledge that I am financially responsible for any non-covered services.

Signature _____ Date _____

Meridian Pediatrics
Patient Information 2

Name _____ Date

Birth History

Place of Birth (Hospital)_____ City _____ St. _____

Birth Weight_____

Complications in Nursery (Please check if occurred)

	Congenital Abnormalities		Respiratory Distress
	Infection		Other:
	Jaundice		
	Premature		

Patient History

Allergies : NO _____ Yes _____Please List _____

Are your child's immunizations up to date? No _____ Yes _____

Medications & Dosages _____

_____

_____

Medical Problems/Illnesses

_____

Hospitalizations/Operations (Include Dates)

_____

Previous Doctor _____ Address

Who referred you to us? _____

Check Box If Medical Conditions Present In Blood Relatives (Grandparents, Parents, Brothers, Sisters)

Allergy		Heart Problems		Lung Disease		Seizures	
Asthma		High Blood Pressure		Mental Illness		Stroke	
Cancer		High Cholesterol		Migraines		Vision Problems	
Diabetes		Hyperactivity		Thyroid Problems		Other	
Hearing Problems		Kidney Problems		Tuberculosis		Other	

Emergency Name & Number (Person other than parent to contact in case of emergency.)

Name _____ Phone _____

Relationship to child_____ Address _____

Signature_____