CHOC Children's
Primary Care Network

Patient Information Form

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 Pacific Islander___
White___ Unknown___

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: _____
SSN: _____/____/_____ Birthday: ___ /___/____
Occupation: _____

Please circle one.
Mother/Father/Guardian: _____
Address (if different from patient's):
_____
Cell Phone: (____) _____-_____
Email: _____
Employer: _____
SSN: _____/____/_____ Birthday: ___ /___/____
Occupation: _____

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: _____
Subscriber Name: _____
ID #: _____
Group #: _____

Secondary Insurance Information
Insurance Name: _____
Subscriber Name: _____
ID #: _____
Group #: _____

Siblings Names	Date of Birth
_____	_____
_____	_____
_____	_____

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

Name/Signature: _____ Date: _____