Patient Identification Information

Child's Last Name:	First Name:	Middle Name:	Sex:	DOB:

Race: ☐ African American ☐ Asian ☐ Native American/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
Ethnicity: ☐ Latino/Hispanic ☐ Not Latino/Hispanic
Primary Language Spoken in Home ______________________________

Patient's Preferred Provider:

Parent / Guardian's Information

Last Name:	First Name:	MI:	Sex:	DOB:
Address:	City:	State:		ZIP:
Home Phone:		Cell Phone:		
E-Mail Address:				
Employer:		Occupation:		

Parent / Guardian's Information

Last Name:	First Name:	MI:	Sex:	DOB:
Address:	City:	State:		ZIP:
Home Phone:		Cell Phone:		
E-Mail Address:				
Employer:		Occupation:		

Insurance

Name of Insurance:	Effective Date:	Customer Service Telephone Number:
Policyholder's Name:		DOB:
Member Number:	Group Number:	

Signature of Person Completing This Form:	Date:

How did you hear about Interlachen Pediatrics?

☐ Currently Established ☐ Friend/Family ☐ Hospital ☐ Insurance Company ☐ IP Website ☐ OB/GYN ☐ Other

Name of Friend, Doctor, Hospital or Other Source of Referral: ______________________________

Thank you for allowing us to care for your child!

23235_I40301 (10/17)