INTERLACHEN PEDIATRICS

Patient Identification Information

Account #

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

Father's Information

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

Mother's Information

Last Name:	First Name:		MI:	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 choosing our practice to care for your child(ren)!