



Patient's name: _____
Last First Middle

Date of Birth: _____ Circle One: Male Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Email Address: _____

Circle One: Black White Hispanic Asian Indian

Circle One: Hispanic Non Hispanic Language: English Spanish Other

Please list siblings name and date of birth:

Father's Name: _____ Date of Birth: _____

Father's Employer: _____

Mother's Name: _____ Date of Birth: _____

Mother's Employer: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____ Relationship: _____

Primary Doctor: _____

(TURN OVER)

Primary Insurance Company: _____

Subscriber ID Number: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber SSN: _____ Subscriber Phone Number: _____

Subscriber Address (if different from patient): _____

Secondary Insurance Company: _____

Subscriber ID Number: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber SSN: _____ Subscriber Phone Number: _____

Subscriber Address (if different from patient): _____

Lab Waiver: Certain lab specimens are sent to outside laboratories for processing. We will make every effort to send your specimen to a laboratory that participates with your insurance carrier. However, if your specimen is sent to a non-participating lab, Primary Pediatrics, P.C. will not be responsible for any fees incurred. It is your responsibility to know your insurance policy and which laboratories are contracted with your plan. Please circle your preferred lab.

Quest Lab Corp Atrium

Guarantor Name: _____

Guarantor Signature: _____

Date: _____