

Patient Information Sheet Annual Update Mandatory 1/28/2015



Benton Pediatrics

Today's Date: _____

Patient's Name: _____ DOB _____ Sex _____

Race _____ Primary Language Spoken _____

Ethnic group (choose one): Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Name of person filling out sheet: _____ Relationship to patient: _____

Patient's Primary Address - Where Patient Lives

Parent / Guardian Name _____ Birth Date _____ SS# _____

Relationship to Patient _____ Email Address _____

Mailing Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

** What phone number should we call to confirm previously scheduled appointments? _____

Employer _____

Other Parent or Legal Guardian

Name _____ Birth Date _____ SS# _____

Relationship to Patient _____ Email Address _____

Mailing Address _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Employer _____

Person To Be Notified In Event Of Emergency (other than parent):

Name _____ Relationship _____ Phone# _____

Insurance Information:

Who carries insurance? (Policy Holder) _____ DOB _____

Name of Insurance Company _____

Policy # _____ Group Name and/or # _____

Pharmacy Information:

Name of Pharmacy preferred _____

Location of Pharmacy _____

• Whom may we thank for your referral to Benton Pediatrics? _____