Welcome to Lake Pointe Pediatric Associates

Patient Information

Patient Name _____
Address_____
City _____
State _____
Zip _____
Home # _____
Sex _____M _____F
Age _____
Birthdate _____

Insurance Information

Insurance Co_____
Claims Address _____
_____
Ins Phone# _____
ID/Policy# _____
Group # _____
Relationship to Patient _____

Parent/Guardian Information

Father:
Name _____
Birthdate_____
Social Security# _____
Cell Phone _____
Employer _____
Work Phone _____
Driver's License _____
State _____
E-Mail _____

Mother:
Name_____
Birthdate _____
Social Security _____
Cell Phone _____
Employer _____
Work Phone _____
Driver's License _____
State _____
E-Mail _____

If parents are separated, who has custody?
_____

In Case of Emergency Notify:
(other than parent/guardian)

Name_____
Relationship_____
Address_____
_____
Telephone _____

Siblings

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

KEEPING YOUR CHILD HEALTHY IS OUR PRIORITY

☐ Please check this box if the information on this form applies to all siblings.

Signature _____ Date _____