MID-OHIO PEDIATRICS & ADOLESCENTS, INC.

595 COPELAND MILL RD.

WESTERVILLE, OH 43081

ACCT# _____

****ALL INFORMATION MUST BE COMPLETED****

How did you hear about us:

CHILD INFORMATION

Childs Legal Last Name _____ Legal First Name _____ MI _____ Nickname _____

Male____ Female____

Date of Birth _____ Transgender____ Phone Number for Appointment Reminders _____

Childs Residential Address _____ City _____ State _____ Zip _____

PARENT/LEGAL GUARDIAN (responsible for bills and payment)

Last Name _____ First Name _____ Male____ Female____ Transgender____

Date of Birth _____ Primary Contact Number _____ Home Cell _____ Secondary Contact Number _____ Cell Work

Address _____ Check if same as childs _____ City _____ State _____ Zip _____

EMAIL ADDRESS _____

RELATIONSHIP TO CHILD (check all that apply): ___ Mother ___Father ___Stepmother ___Stepfather ___Legal Guardian ___Primary Care Giver ___Other

PARENT/LEGAL GUARDIAN

Last Name _____ First Name _____ Male____ Female____ Transgender____

Date of Birth _____ Primary Contact Number _____ Home Cell _____ Secondary Contact Number _____ Cell Work

Address _____Check if same as childs _____ City _____ State _____ Zip _____

RELATIONSHIP TO CHILD (check all that apply): ___ Mother ___Father ___Stepmother ___Stepfather ___Legal Guardian ___Primary Care Giver ___Other

ADDITIONAL CONTACT (Optional)

Last Name _____ First Name _____ RELATIONSHIP TO CHILD (Check all that apply) ___ Mother ___Father ___Stepmother ___ Stepfather ___Primary Care Giver ___Other

Phone Number _____ Cell Home

MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ___ Yes ___ No

PREFERRED PHARMACY

Pharmcy Name _____ Address _____ Phone Number _____

INSURANCE (Please present all current insurance cards to the Front Desk)

****Failure to disclose all current insurance coverage including State Funded insurance may result in dismissal from our practice****

Primary Insurance Company _____ Policy Holders Full Name _____ Date Of Birth _____

ID/Subscriber Number _____ Group Number _____ Policy Effective Date _____

Is the Insurance through; (circle one)

Employer MarketPlace State Funded Individual Policy Copay Amount _____ Relationship To Patient _____

Secondary Insurance Company _____ Policy Holders Full Name _____ Date Of Birth _____

ID/Subscriber Number _____ Group Number _____ Policy Effective Date _____

Is the Insurance through; (circle one)

Employer MarketPlace State Funded Individual Policy Copay Amount _____ Relationship To Patient _____

Parent or Legal Guardian Printed Name _____ Parent or Legal Guardian Signature _____ Date Signed _____

****Please provide a copy of any documents related to custodial rights for the the patient's record****