ALL INFORMATION MUST BE COMPLETED

MID-OHIO PEDIATRICS & ADOLESCENTS, INC.
465 N. CLEVELAND AVE. SUITE 200
WESTERVILLE, OH 43082

ALL INFORMATION MUST BE COMPLETED

CHILD INFORMATION

Childs Legal Last Name ____ Legal First Name ____ MI ____ Nickname ____

Date of Birth ____ Male____ Female____ 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

SIBLINGS WHO COME TO OUR OFFICE (with the same parent responsible for bills)

First Name ____ Last Name ____ Brother____ Sister____ Step___

First Name ____ Last Name ____ Brother____ Sister____ Step___

First Name ____ Last Name ____ Brother____ Sister____ Step___

First Name Last Name Brother____ Sister____ Step___

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****