Pediatric Care
of Greater Cleveland

Welcome to Pediatrics Care at Premier Physician

Thank you for choosing our practice. All Information will be STRICTLY CONFIDENTIAL.

Patient Legal Name (First, Middle, Last) _____ DOB (M/D/Y) _____ Today's Date _____

Race: (circle one)	**Ethnicity: (circle one)**	**Language: (circle one)**
❑ Asian	❑ Hispanic	❑ English
❑ Black/African American	❑ Non-Hispanic	❑ French German
❑ Caucasian	❑ White	❑ Hindi
❑ Chinese	❑ Other	❑ Mandarin
❑ Hispanic		❑ Spanish
❑ Japanese	**Sex (circle one)**	❑ Vietnamese
❑ American Indian or Alaska Native	❑ Male	❑ Other
❑ Latino	❑ Female	
❑ Multiracial		
❑ Pacific Islander		
❑ Other		

Street Address _____

City / State / Zip _____

Mailing Address (if different from the street address) _____

Home Phone: _____ Patient Cell (If 13+) _____ Email _____

Who referred you to the office? _____

Mother/Guardian's Name: _____ _____

Relationship to Child:

_____ _____

Work/Cell Phone DOB (M/D/Y)

Father/Guardian's Name: _____ _____

Relationship to Child:

_____ _____

Work/Cell Phone DOB (M/D/Y)

Patient's Primary Care Doctor (as listed with Insurance company)

_____

PERSON RESPONSIBLE FOR BILL: (must be parent/guardian)

_____ _____ _____

Mother/Guardian (First, Middle, Last) SS# DOB (M/D/Y)

_____

Street Address **(If different from above)**

_____

City / State / Zip

_____

Insurance ID #

_____ _____

Insurance Group CoPay

_____ _____ _____

Father/Guardian (First, Middle, Last) SS# DOB (M/D/Y)

_____

Street Address **(If different from above)**

_____

City / State / Zip

_____

Insurance ID #

_____ _____

Insurance Group CoPay

Insurance Information: (patients are required to show insurance cards at all visits)

_____

Signature of Patient/Parent/Legal Guardian **Date**