FENTON MEDICAL CENTER

NEW PATIENT **CHILD** FACE SHEET

DATE:			PATIENT NAME:
DOB:	BIRTHWEIGHT:		SEX: MALE FEMALE
ADDRESS:			HOME TELEPHONE:
CITY:	STATE:	ZIP CODE:	EMAIL:
INSURANCE:		MEDICAID:	
CARDHOLDER'S FULL NAME & DATE OF BIRTH:		CARDHOLDER'S RELATIONSHIP TO PATIENT:	
GROUP #	CONTRACT #:	CO-PAY:	
NAME OF SECONDARY INSURANCE:		CARDHOLDER'S FULL NAME & RELATIONSHIP:	

BIOLOGICAL FATHER'S INFORMATION-

NAME: ____________________

DOB: ____________________

SS#: ____________________

PHONE #: ____________________

OCCUPATION: ____________________

EMPLOYER: ____________________

EMPLOYER PHONE #: ____________________

INSURANCE: ____________________

GROUP # / CONTRACT # ____________________

STEP FATHER'S INFORMATION (IF APPLICABLE)-

NAME: ____________________

DOB: ____________________

SS#: ____________________

PHONE #: ____________________

OCCUPATION: ____________________

EMPLOYER: ____________________

EMPLOYER PHONE #: ____________________

INSURANCE: ____________________

GROUP # / CONTRACT #: ____________________

BIOLOGICAL MOTHER'S INFORMATION-

NAME: ____________________

DOB: ____________________

SS#: ____________________

PHONE #: ____________________

OCCUPATION: ____________________

EMPLOYER: ____________________

EMPLOYER PHONE #: ____________________

INSURANCE: ____________________

GROUP # / CONTRACT #: ____________________

STEP MOTHER'S INFORMATION (IF APPLICABLE)-

NAME: ____________________

DOB: ____________________

SS#: ____________________

PHONE #: ____________________

OCCUPATION: ____________________

EMPLOYER: ____________________

EMPLOYER PHONE #: ____________________

INSURANCE: ____________________

GROUP # / CONTRACT #: ____________________

EMERGENCY INFORMATION-

CONTACT PERSON: ______________________________

RELATIONSHIP: ______________________________

TELEPHONE #: ______________________________

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PLEASE READ AND SIGN BELOW: I acknowledge that all the information given is correct. I accept responsibility for any charges incurred by myself or a family member while on my account. I am aware that fees for services are expected at time of service and that a monthly re-bill fee of $5.00 is charged on unpaid accounts.

Signature: ______________________________ Date: ______________________________