## NORTHLAKE PEDIATRIC CARE, P.A.

Child's Full Name: ______________________________________________
(LAST) (FIRST) (MIDDLE)

Address: ____________________ City: ______________State_______ Zip____________

Child's Date of Birth: _________/__________/__________ Child's Social Security # ____________-______________-______________________

Parents Full Name: ______________________________________________
(LAST) (FIRST) (MIDDLE)

Parents Date of Birth: ________/__________/___________ Parents Social Security # _____________-_______________-___________________

Home Phone # _____________________________________________Cell Phone # _____________________________________________________

Emergency Contact Name: _______________________________________ Emergency Contact # _________________________________________

E-mail Address: ____________________________________________________________________________________________________

Pharmacy: _________________________________________

Race:_________________________ Ethnicity______________________ Preferred Language_________________________________

## INSURANCE INFORMATION

Primary Insurance Company: ________________________________________________ Effective Date: ___________________________________

Insurance ID # ______________________________________________________ Group # _______________________________________________

Who carries the child on this insurance? ______________________________________________
(LAST) (FIRST) (MIDDLE)

Place of Employment: __________________________________________________ Work # ______________________________________________

Insurance carriers Date of Birth ____________/___________/______________ Social Security # __________-____________-__________________

Relation to child: ______________________________________

Address, if different from child's home: ______________________________________________

Secondary Insurance Company: ______________________________________________ Effective Date: ___________________________________

Insurance ID # ______________________________________________________ Group # _______________________________________________

Who carries the child on this insurance? ______________________________________________
(LAST) (FIRST) (MIDDLE)

Place of Employment: _________________________________________________ Work # _______________________________________________

Insurance carriers Date of Birth __________/_____________/______________ Social Security # __________-_____________-_______________

Relation to child: ______________________________________

Address, if different from child's home: ______________________________________________

I hereby authorize treatment from Dr. Michael G. Borja, and to release any medical information necessary to settle insurance claims. The information I have provided is correct to the best of my knowledge.

______________________________________________
(PARENT/LEGAL GUARDIAN) (DATE)