ARK-LA-TEX CHILDREN'S CLINIC, 2400 HOSPITAL DRIVE, SUITE 120, BOSSIER CITY, LA 71111
PATIENT INFORMATION FOR PATIENTS <18YO

☐ DR. SANDERS ☐ DR. HUGHES ☐ DR. SINGH ☐ DR. GARDNER ☐ DR. MILNER

FULL NAME:_____GOES BY:_____

DOB:_____ GENDER:_____ SSN:_____ RACE:_____

ADDRESS:_____ CITY:_____STATE:_____ZIPCODE:_____

RESPONSIBLE PARTY:_____RELATIONSHIP TO PATIENT:_____

RESPONSIBLE PARTY ADDRESS ☐ IF SAME AS ABOVE):_____

FATHER'S FULL NAME:_____GOES BY:_____

DOB:_____ SSN:_____ DRIVERS LICENSE #:_____ EMPLOYER:_____

☐ √ If address same as above:_____

EMAIL: _____ WORK #: _____ DAD CELL #:_____

√ ALL THAT APPLY: ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED ☐ SINGLE ☐ ADOPTIVE PARENT/LEGAL GUARDIAN ☐ DECEASED

MOTHER'S FULL NAME:_____GOES BY:_____

DOB:_____ SSN:_____ DRIVERS LICENSE #:_____ EMPLOYER:_____

☐ √ if address same as above:_____

EMAIL: _____ WORK #: _____ MOM CELL#:_____

√ ALL THAT APPLY: ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED ☐ SINGLE ☐ ADOPTIVE PARENT/LEGAL GUARDIAN ☐ DECEASED

EMERGENCY CONTACT (NOT LIVING IN SAME HOUSEHOLD):_____

PHONE#:_____ RELATIONSHIP TO PATIENT:_____

IS PATIENT COVERED BY MEDICAL INSURANCE: ☐ YES ☐ NO

INSURANCE COMPANY:_____ POLICY #:_____

INSURED NAME:_____ GROUP #:_____

IF YOU ARE A NEW PATIENT, WHO CAN WE THANK FOR YOUR REFERRAL?_____

SIBLINGS:_____

As the parents or guardians of the patient listed above, we authorize the release of any medical or other information necessary to process this claim. Also, we authorize payment of medical benefits to the Ark-La-Tex Children's Clinic. We understand that we are financially responsible for any remaining balance not paid by insurance. We also acknowledge that it is our responsibility to complete an updated form anytime the above information changes or whenever requested by Ark-La-Tex Children's Clinic.

_____ _____ _____

SIGNATURE OF PARENT/GUARDIAN | RELATIONSHIP TO PATIENT | DATE