Blue Sky Pediatrics
Asheville

PRIMARY CAREGIVER (CIRCLE)

Kowa Alweiss Brown

ESTABLISHED PATIENTS UPDATE
PLEASE FILL IN ALL LINES

PATIENT INFORMATION FORM

Do you want patient portal access? (Circle) Yes or No

PLEASE CIRCLE ONE ANSWER WHEN GIVEN CHOICES UNDER SEX, ETHNICITY AND RACE (Required under new medical guidelines)

CHILD'S NAME _____ _____
Last First Middle Telephone Number

CHILD'S DATE OF BIRTH _____ CHILD'S SOCIAL SECURITY # _____

CHILD'S ADDRESS _____
Street Address City State ZIP

PREFERRED LANGUAGE _____ ETHNICITY: (Hispanic, Non-Hispanic, Refuse to report)

RACE: (American Indian or Alaska Native, Asian, Black or African American, **If more than one race, circle both races**, Native Hawaiian, Other Pacific Islander, Refuse to report, White) SEX: (MALE or FEMALE)

FATHER'S NAME _____ MARRIED/SEPARATED/DIVORCED/SINGLE/DECEASED

FATHER'S DATE OF BIRTH _____ FATHER'S SOCIAL SECURITY # _____ (Circle One)

FATHER'S ADDRESS _____
Mailing Address City State ZIP

FATHER'S EMPLOYER AND ADDRESS _____

FATHER'S HOME PHONE _____ FATHER'S WORK PHONE _____

FATHER'S CELL PHONE _____ EMAIL ADDRESS _____

MOTHER'S NAME _____ MARRIED/SEPARATED/DIVORCED/SINGLE/DECEASED

MOTHER'S DATE OF BIRTH _____ MOTHER'S SOCIAL SECURITY # _____ (CIRCLE ONE)

MOTHER'S ADDRESS _____
Mailing Address City State ZIP

MOTHER'S EMPLOYER AND ADDRESS _____

MOTHER'S HOME PHONE _____ MOTHER'S WORK PHONE _____

MOTHER'S CELL PHONE _____ EMAIL ADDRESS _____

MOTHER'S MAIDEN NAME (FOR IMMUNIZATION RECORD) _____

NEAREST RELATIVE NOT LIVING WITH YOU:

_____
NAME RELATIONSHIP PHONE # CELL #

INSURANCE INFORMATION:

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____
Last First Middle

POLICY HOLDER'S ADDRESS _____
Street Address City State ZIP

POLICY HOLDER'S DATE OF BIRTH _____ SOCIAL SECURITY # _____

INSURANCE COMPANY'S NAME _____

(PLEASE PROVIDE COPY OF THE CARD TO THE RECEPTIONIST AT EVERY VISIT)

I hereby authorize payment for medical benefits to the physicians of Blue Sky Pediatrics Asheville PA and also authorize said physicians to release to insurance carriers all requested information to process claims when the above child is seen.

SIGNED _____ PRINTED NAME _____

RELATIONSHIP TO CHILD _____ DATE _____