

Children's Health Partners, SC

Patient Information Form

Patient Information:

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Sex: Male Female

Home Address: _____ City: _____ Zip: _____

Subdivision Name: _____

Home Phone: _____ Name of school:
(if attends) _____

Siblings:

Name: _____ Birthdate: _____

Parent's Information:

Mother's Name: _____ Father's Name: _____

Complete Address (If different than patient): _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Profession/Job Title: _____ Profession/Job Title: _____

Employer: _____ Employer: _____

Social Security #: _____ Social Security #: _____

Birthdate: _____ Birthdate: _____

Insurance Information:

Insurance Company: _____

Policy Holder: _____

ID Number: _____ Group Number: _____

How did you hear about Children's Health Partners?

- Physician _____
 Friend _____
 Edward Hospital Physician Referral Service
 Cradle Talk
 Other _____