



Welcome to Lake Country Pediatrics, S.C.

Patient Information			
New Patients: HOW DID YOU HEAR ABOUT US? _____			
Name (First, Middle, Last)	Sex (M/F)	Date of Birth	Social Security Number

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Household Email: _____

Address: _____ City: _____ State: _____ Zip: _____

If Patient is a minor, fill out the following section. If patient is NOT a minor, continue to the section on insurance information.

Parent/Guardian Information:

First Name: _____ Middle Initial: _____ Last Name: _____ Gender (M/F/Other) _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Occupation: _____

Work Phone: (____) _____ Employer's Name: _____

Cell Phone: (____) _____ Date of Birth: _____ SSN: _____

Lake Country Pediatrics, S. C. may contact or leave a message on:

Home Phone: Yes ___ No ___ Cell Phone: Yes ___ No ___ Work Phone: Yes ___ No ___

Parent/Guardian Information:

First Name: _____ Middle Initial: _____ Last Name: _____ Gender (M/F/Other) _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Occupation: _____

Work Phone: (____) _____ Employer's Name: _____

Cell Phone: (____) _____ Date of Birth: _____ SSN: _____

Lake Country Pediatrics, S. C. may contact or leave a message on:

Home Phone: Yes ___ No ___ Cell Phone: Yes ___ No ___ Work Phone: Yes ___ No ___

Who does child live with? Mom ___ Dad ___ Both ___ Other ___

If other, what is the relationship to child? _____

Insurance Information (We can make a copy of your card.)

PLEASE NOTE: your insurance requires payment of your copay at the time of service.

If patient is a minor, who carries the insurance for the patient? Mom ___ Dad ___ Other ___

Subscriber's Name (person who carries insurance): _____

Subscriber's Date of Birth: _____ Insurance effective date: _____

PRIMARY Insurance: _____

Plan ID # _____ Group # _____