PRIVIA
MEDICAL GROUP

Patient Information	**Today's Date**
Last Name	**Mother's** Name (last, first)
First Name	Address
Middle Name	
Former Last Name	Date of Birth
Sex	Mobile Phone
DOB	Mother's SSN#
SSN	**Guardian/Father Name** (last, first)
Address	Address
Address 2	
Zip	Date of Birth
City	Mobile Phone
State	Father's SSN#
Home Phone	Siblings **Names**
Mobile Phone	
Work Phone	
Email (required) Mom/Dad	
Preferred Pharmacy	**Guarantor Information**
Contact Preference (please circle): HOME MOBILE WORK	Last Name
Language	First name
Race	Middle Name
Ethnicity	DOB
Marital Status	Address
Does Patient Reside with (choose one) Mother Father Both Other	
If parents are divorced or separated, what is the custody status?	Zip
Emergency contact	City
Emergency contact phone #	State

Primary Insurance Information	**Secondary Insurance Information**
Insurance Plan Name	Insurance Plan Name
ID/Certification #	ID/Certification #
Policy/Group #	Policy/Group #
Primary Policy Holder (if other than Patient)	**Secondary Policy Holder (if other than patient)**
Patient's relationship to policy holder	Patient's relationship to policy holder
Last Name	Last Name
First Name	First Name
Middle Name	Middle Name
Address	Address
City	City
State	State
Zip	Zip
Date of Birth	Date of Birth
Policy Holder Sex	Policy Holder Sex
Employer Name	Employer Name

*** **Note: The person bringing the child to the office for medical treatment is responsible for co-payment AT THE TIME OF SERVICE.**

If our provider is not a Participating Provider with your insurance company, payment in full is required at time of service.

I certify that the information on this form is current and accurate to the best of my knowledge.

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Signature of Patient/Parent/Guardian **Relationship** **Date**