



1912 Hayes Avenue  
Sandusky, Ohio 44870  
419-502-2800

### CHILD PATIENT INFORMATION

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_  
(for statistical purposes only)  
Previous Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### PARENT / GUARDIAN INFORMATION (please circle one)

Mother's/Guardian's Name \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_  
Mother's/Guardian's Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mother's/Guardian's Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Father's/Guardian's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Father's/Guardian's Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Father's/Guardian's Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Phone \_\_\_\_\_  
(other than Spouse/Parent/Guardian)

### PATIENT INSURANCE COVERAGE

Primary Insurance \_\_\_\_\_ Group/ID # \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Group/ID # \_\_\_\_\_

**DOES PATIENT HAVE MEDICAID OR MEDICARE COVERAGE?** Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please give # below)

Medicaid # \_\_\_\_\_ Medicare # \_\_\_\_\_

**IS PATIENT SELF-PAY?** Yes \_\_\_\_\_ No \_\_\_\_\_ (A sliding fee scale is required for all self-pay patients)

**I hereby authorize the release of any medical information necessary for the processing of insurance. I also authorize insurance benefits to be paid directly to Family Health Services of Erie County. I understand that if my insurance does not pay, I am responsible for payment of services provided.**

Signature \_\_\_\_\_ Date \_\_\_\_\_