FENTON MEDICAL CENTER
NEW PATIENT **CHILD** FACE SHEET

DATE:	PATIENT NAME:		
DOB:	BIRTHWEIGHT:		SEX: MALE FEMALE
ADDRESS:			HOME TELEPHONE:
CITY:	STATE:	ZIP CODE:	EMAIL:
INSURANCE:		MEDICAID:	
CARDHOLDER'S FULL NAME:		CARDHOLDER'S RELATIONSHIP TO PATIENT:	
GROUP #	CONTRACT #:	CO-PAY:	
NAME OF SECONDARY INSURANCE:		CARDHOLDER'S FULL NAME & RELATIONSHIP:	

FATHER'S INFORMATION-

NAME: _____

DOB: _____

SS#: _____

OCCUPATION: _____

EMPLOYER: _____

EMPLOYER PHONE #: _____

INSURANCE: _____

GROUP #: _____

CONTRACT #: _____

CO-PAY: _____

MOTHER'S INFORMATION-

NAME: _____

DOB: _____

SS#: _____

OCCUPATION: _____

EMPLOYER: _____

EMPLOYER PHONE #: _____

INSURANCE: _____

GROUP #: _____

CONTRACT #: _____

CO-PAY: _____

EMERGENCY INFORMATION-

CONTACT PERSON: _____

RELATIONSHIP: _____

TELEPHONE #: _____

PLEASE READ AND SIGN BELOW: I acknowledge that all the information given is correct. I accept responsibility for any charges incurred by myself or a family member while on my account. I am aware that fees for services are expected at time of service and that a monthly re-bill fee of $5.00 is charged on unpaid accounts.

Signature: _____ Date: _____