The Children's Hospital of Philadelphia

a pediatric healthcare network

DATE: ____________________

1. **PATIENT INFORMATION**

NAME: ____________________ DATE OF BIRTH: __________ SEX: __________

SOCIAL SECURITY #: ____________ RACE/ETHNIC GROUP: ____________________

MARITAL STATUS: ____________ RELIGION: ____________________

STREET ADDRESS: ____________________ APT NO: ____________

CITY, STATE: ____________________ ZIP: ____________________

COUNTY: __________ PHONE: ____________________

2. **RESPONSIBLE PARTY** **(Parent/Legal Guardian who is responsible for the bill)**

NAME: ____________________ DATE OF BIRTH: __________ RELATIONSHIP TO PATIENT: __________

STREET ADDRESS: ____________________ APT NO: ____________

CITY, STATE: ____________________ ZIP: __________ PHONE: ____________

WORK PHONE: __________ EXT. ______ CELLULAR PHONE: ____________

SOCIAL SECURITY #: ____________ OCCUPATION: ____________

EMPLOYER: ____________________

WORK ADDRESS: ____________________ CITY, STATE: ____________ ZIP: ________

INSURANCE NAME: ____________ **ID #:** ________ **GROUP #:** ____________

INSURANCE ADDRESS: ____________________

Please present Insurance Card to front desk so they can make a copy of the front and back of the card

3. **OTHER PARENT** **(Other than Responsible Party)**

NAME: ____________________ DATE OF BIRTH: __________ RELATIONSHIP TO PATIENT: __________

STREET ADDRESS: ____________________ APT NO: ____________

CITY, STATE: ____________________ ZIP: __________ PHONE: ____________

WORK PHONE: __________ EXT. ______ CELLULAR PHONE: ____________

SOCIAL SECURITY #: ____________ OCCUPATION: ____________

EMPLOYER: ____________________

WORK ADDRESS: ____________________ CITY, STATE: ____________ ZIP: ________

INSURANCE NAME: ____________ **ID #:** ________ **GROUP #:** ____________

INSURANCE ADDRESS: ____________________

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4. **ADDITIONAL (EMERGENCY) CONTACT**

NAME: ____________________ RELATIONSHIP TO PATIENT: ____________________

STREET ADDRESS: ____________________ APT NO: ____________________

CITY, STATE: ____________________ ZIP: __________ HOME PHONE: __________

WORK PHONE: ____________ CELLULAR PHONE: ____________