The Children's Hospital of Philadelphia
a pediatric healthcare network

DATE: _____

1. **PATIENT INFORMATION**

NAME: _____ DATE OF BIRTH: _____ SEX: _____

RACE/ETHNIC GROUP: _____ MARITAL STATUS: _____

RELIGION: _____

STREET ADDRESS: _____ APT NO: _____

CITY, STATE: _____ ZIP: _____ COUNTY: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

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: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____

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: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____

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

4. **ADDITIONAL (EMERGENCY) CONTACT**

NAME: _____ RELATIONSHIP TO PATIENT: _____

STREET ADDRESS: _____ CITY, STATE _____ ZIP:_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____