Coastal Pediatrics

Patient Information

Patient Name:	Date of Birth: Social Security Number:	Gender: Male☐ Female☐
Child's Race:	Child's Ethnicity:	Patient Adopted or In Custody: ☐Yes (if yes, please provide legal documentation tor patient's chart) ☐No

Parent/Legal Guardian Information

Parent/Legal Guardian 1:	Parent/Legal Guardian 2:
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:
Address:	Address:
Primary Phone Number:	Primary Phone Number:
Secondary Phone Number:	Secondary Phone Number:
Email Address:	Email Address:

Private Primary Insurance

Plan Name:	Polley ID#:	Group#:
Policy Holder Name:	Date of Birth:	SS#:

Private Secondary Insurance

Plan Name:	Policy ID#:	Group#:
Polley Holder Name:	Date of Birth:	SS#:

Parent or legal Guardian Signature:

Date.