



Miller Children's Outpatient Specialty Centers - Patient Information

(Please fill-out all sections completely and accurately)

Intaker's Initials: _____

Today's Date: _____ Appointment Date: _____ Time: _____ am/pm

Referred to MD: _____ Referring MD: _____ Telephone: _____

Complaint/Dx: _____ ICD 9 Code: _____

Patient's Last Name: _____ First Name: _____ MI: _____

DOB: _____ Sex: _____ AKA: _____

Address: _____ Apt # _____ City: _____ Zip Code: _____

Home Telephone #: _____ SSN: _____ - _____ - _____ Language: _____

OPTIONAL: (IF known) MR#: _____ Race: _____ Religion: _____

CareTaker 1: _____ Relationship to Patient: _____

Caretaker 2: _____ Relationship to Patient: _____

IN CASE OF EMERGENCY (must be completed with info from parents – request contacts other than parents)

Emergency Contact Name: _____ Day Telephone: () _____

Relationship to Patient: _____ Home Telephone: () _____

OPTIONAL: 2nd Emergency Contact Name: _____ Day Telephone: () _____

Relationship to Patient: _____ Home Telephone: () _____

RESPONSIBLE PARTY (GUARANTOR) (Is Caretaker the Guarantor? If so, indicate "same as above")

Last Name: _____ First Name: _____

Address (if different): _____ Zip Code: _____

Home Telephone (if different): () _____ Work Telephone: () _____

DOB: _____ Sex: _____ SSN: _____ - _____ - _____ Employed By: _____

Employer's Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ IPA/Medical Group: _____

Telephone: _____ Fax: _____

Claims Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Subscriber #: _____

Subscriber: _____ SSN: _____ - _____ - _____ Group #: _____

Eligibility Date: _____ Deductible/Share of Cost/Co-pay: \$ _____

PCP: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: () _____

Fax #: () _____ Authorization #: _____ Expiration: _____

Authorization Form Attached: Yes / No Parent to Bring Authorization: Yes / No

Advised patient/parent to bring all laboratory results, medical or other pertinent information to initial visit.

Please Turn Over and Complete Other Side!

Pre-Admission Referral Information

SECONDARY INSURANCE INFORMATION (complete if applicable)

Insurance Name: _____ IPA/Medical Group: _____

Telephone: _____ Fax: _____

Claims Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Subscriber #: _____

Subscriber: _____ SSN: _____ - _____ - _____ Group #: _____

Eligibility Date: _____ Deductible/Share of Cost/Co-pay: \$ _____

PCP: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: () _____

Fax #: () _____ Authorization #: _____ Expiration: _____

Authorization Form Attached: Yes / No Parent to Bring Authorization: Yes / No

COMMENTS: