



Patient Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ SS#: _____

Referred by: _____

DEMOGRAPHIC INFORMATION

Father's Name: _____ Date of Birth: _____

SS#: _____ Driver License # _____ State: _____ Exp: _____

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Employer: _____

Mother's Name: _____ Date of Birth: _____

SS#: _____ Driver License # _____ State: _____ Exp: _____

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Employer: _____

INSURANCE INFORMATION

Insurance Name: _____

Policy or ID#: _____ Group#: _____

Policy Holder Name: _____ Effective Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

I give Step by Step Pediatrics/Dr. Letisha Sneed permission to provide care to my child as deemed necessary. I also grant permission for the above mentioned to bill my insurance company for services provided and understand that in the event my insurance provider does not pay for such services I will be held responsible for any unpaid balance and collection fees if applicable. I have also reviewed a copy of the HIPPA policy, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Parent/Guardian Signature

Date