Lehigh Valley Peds

PATIENT INFORMATION 18 & OLDER

Date _____

Last Name _____
First Name _____
Middle Name _____
Address _____
City/State _____
Zip Code _____

Home # _____
Work # _____
Cell Phone # _____
DOB _____
Social Security # _____
Employer Name _____
Employer Address _____
Email Address _____

INSURANCE INFORMATION

Primary Plan _____
Employer Name _____

Policy Address _____
Policy/Member ID # _____

Name of Policy Holder _____
Policy Holder DOB _____
Relationship to Patient _____
City/State/Zip _____
Group # _____

Secondary Plan _____
Employer Name _____

Policy Address _____
Policy/Member ID # _____

Name of Policy Holder _____
Policy Holder DOB _____
Relationship to Patient _____
City/State/Zip _____
Group # _____

Mother/Guardian

Name _____
Address _____
_____
Main Contact # _____

Father/Guardian

Name _____
Address _____
_____
Main Contact # _____

The information on this patient information form is current and up-to-date. I understand that I will be responsible for any and all services denied by my insurance company due to any incorrect information on this form.

Signature of Patient _____