



Welcome to our Practice

Patient information

Last name: _____
First name: _____ Middle initial: _____
Date of birth: _____
Gender: Male Female Other
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone: _____
Email: _____
Race: _____
Ethnicity: _____
Primary language: _____
Primary care physician (PCP): _____

Parent/Guardian information

Parent/Guardian #1 first name: _____
Last name: _____ Date of birth: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone: _____
Email: _____
Responsible for payment? Yes No

Parent/Guardian #2 first name: _____
Last name: _____ Date of birth: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone: _____
Email: _____
Responsible for payment? Yes No

Primary emergency contact

Parent/Guardian #1 Parent/Guardian #2
 Other: _____

Medical insurance

Policy holder last name: _____
Policy holder first name: _____
Insurance name: _____
Group #: _____
Member #: _____
Child #1 last name: _____

Pharmacy:

Address: _____

Other children

Child #1 last name: _____
First name: _____ Middle initial: _____
Date of birth: _____
Gender: Male Female Other
Child #2 last name: _____
First name: _____ Middle initial: _____
Date of birth: _____
Gender: Male Female Other
Child #3 last name: _____
First name: _____ Middle initial: _____
Date of birth: _____
Gender: Male Female Other

How did you hear about us?

Family/friend Web search Social media
 Print advertisement Other

Assignment of benefits and release of information

I hereby authorize my insurance benefits to be paid to Alena Ashenberg MD, Pediatrics and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Alena Ashenberg MD, Pediatrics to release information requested concerning my care to insurers paying such benefits.

Signature: _____

Date: _____