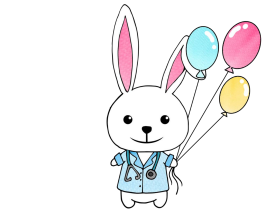

3196 S. Maryland Parkway, Suite 411
Las Vegas, NV 89109

Phone: (702)444-7685
Email: info@healthykidscarelv.org

PATIENT INFORMATION: (Please Print)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Sex: Male / Female Age: _____

PARENT/GUARDIAN INFORMATION:

[ ] Mother | [ ] Father or (If you are not Parent) Relationship to Patient: _____

Mother's First Name: _____
Mother's Last Name: _____
Date of Birth: ____/____/____
Primary Insured: YES / NO

Father's First Name: _____
Father's Last Name: _____
Date of Birth: ____/____/____
Primary Insured: YES / NO

Sibling Name: _____
Date of Birth: _____
Sibling Name: _____
Date of Birth: _____
Sibling Name: _____
Date of Birth: _____
Sibling Name: _____
Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Ethnicity: _____

EMERGENCY CONTACT: (Other than yourself)

Name: _____ Relationship to Patient: _____

Phone Number: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Member ID: _____ Group #: _____

Name of Subscriber: _____ Subscriber DOB: ____/____/____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Member ID: _____ Group #: _____

Name of Subscriber: _____ Subscriber DOB: ____/____/____

OR Circle One: Medicaid / Health Plan of NV (Smart Choice) / Amerigroup / Silver Summit

Member ID: _____

PHARMACY INFORMATION:

Pharmacy Name: _____ Cross Streets: _____ & _____

Sibling(s) Name: _____

Signature: _____ Today's Date: ____/____/____