



**Patient Information Sheet** Annual Update Mandatory

Benton Pediatrics

Patient's Name: \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_ SS# \_\_\_\_\_

Name of person filling out sheet: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Responsible Party (Guarantor) Information** (Patient's Primary Address)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_  
*Street City State Zip*

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

\*\* What phone number should we call to confirm previously scheduled appointments? \_\_\_\_\_

Employer \_\_\_\_\_

**Spouse or Other Caregiver's Information**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

**Person To Be Notified In Event Of Emergency** (other than parent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

**Insurance Information:**

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group Name and/or # \_\_\_\_\_

• Whom may we thank for your referral to Benton Pediatrics? \_\_\_\_\_