Welcome to our Practice!

Healthy Steps Pediatrics, LLC
NEWBORN to ADOLESCENT

Today's Date: ____/____/_____

Christopher Meyer, MD, FAAP Jessy John, MD, FAAP Constantine Serkes, MD, FAAP

Sarah Smith, CRNP Monica Perme, CRNP

Patient Information:

Name: _____ Date of Birth: ____/____/_____
First Middle Last

Address: _____
Street

_____ _____ _____
City State Zip

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Family Email Address: _____

Preferred Language: _____ Gender: Male ☐ Female ☐

Place of Birth (Hospital/Facility): _____

Patient Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Billing Address: ☐ Same as above ☐ Different from where child resides (Please fill out below):

Address: _____ City _____ State ____ Zip _____

Who lives at this address? _____ Phone # _____

Preferred Local Pharmacy: _____ Pharmacy Phone: (____) _____- _____

Pharmacy Address/Location: _____

How did you learn of our office? _____

Race: (select one or more)

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian
☐ Caucasian ☐ Black or African American ☐ Undisclosed

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Undisclosed

Responsible Party Information:

Mother's Name: _____ Date of Birth: _____

Mother's Cell Phone: _____ Work Phone: _____

Mother's Maiden Name: _____

Mother's Email: _____

Father's Name: _____ Date of Birth: _____

Father's Cell Phone: _____ Work Phone: _____

Father's Email: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Alternate Phone: _____

Insurance Information: *(Please bring your insurance card with you to your appointment.)*

Primary Insurance: _____

Subscriber Name: _____

Subscriber DOB: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

Subscriber Name: _____

Subscriber DOB: _____

ID #: _____ Group #: _____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to the doctor above. This assignment will remain in effect until removed by me in writing. A photocopy of this assignment may be considered valid. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure payment.

Patient (Guardian) Signature: _____ Date: _____/____/_____

Thank you for choosing Healthy Steps Pediatrics!

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