VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
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PATIENT INFORMATION FORM

Patient's Name _____ Male ☐ Female ☐ DOB _____
(First) (M. I.) (Last)

Home Address _____

City _____ State _____ Zip Code _____

Mother _____ DOB _____

Maiden Name _____

Father _____ DOB _____

Mother's Cell # _____ Mother's Work # _____

Father's Cell # _____ Father's Work # _____

NAMES OF OTHER CHILDREN SEEN HERE

NAME	DOB	INSURANCE SUFFIX

Emergency Contact Name _____

Relationship to Patient _____ Phone # _____

Referred By (Rheumatology only) _____

PCP Name _____ PCP Phone # _____

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PATIENT DEMOGRAPHICS

Race ☐ White ☐ Black/African America ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Patient Declined

Ethnicity ☐ Spanish/Hispanic Origin ☐ Not of Spanish/Hispanic Origin ☐ Patient Declined

Language ☐ English ☐ Spanish ☐ Declined ☐ Other _____

PRIMARY INSURANCE INFORMATION

Policyholder's Name _____ Male ☐ Female ☐

Policyholder's Address (if different than patient)

_____

Phone # (if different) _____ Work # _____

Employer _____

Insurance Company _____ ID # _____

Relationship to Patient _____ Co-Pay $ _____ (Sick) $ _____ (Well)

Marital Status (Circle) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legal Status

Primary Pharmacy _____ (Name) Location _____ (Street, Town)

SECONDARY INSURANCE INFORMATION

Policyholder's Name _____ Male ☐ Female ☐

Policyholder's Address (if different than patient)

_____

Phone # (if different) _____ Work # _____

Employer _____

Insurance Company _____ ID # _____

Relationship to Patient _____ Co-Pay $ _____ (Sick) $ _____ (Well)

Marital Status (Circle) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legal Status

Case Manager _____ Phone # _____

Social Worker _____ Phone # _____

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AUTHORIZATION FOR INSURANCE BILLING

I hereby authorize Joan G. Calkins, MD to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Dr. Calkins. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ **Date** _____

Signature _____

RECORD RELEASE AUTHORIZATION

I hereby authorize you to release to Joan G. Calkins, MD, at the aove address, any and all information, including diagnosis and records of any treatment or examination rendered. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ **Date** _____

Signature _____

Dr. Calkins occasionally has students working with her. If you prefer that the students not assist with your child please let a staff member know. Thank you for your understanding and help in this matter. Our students appreciate the opportunity to learn from you!

How did you learn about our Practice?

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