CENTRAL ILLINOIS HEARING, LTD.

PEDIATRIC GENERAL INFORMATION FORM

Patient Name: _____ **Nickname**: _____

Date of Birth: _____ **Age**: _____ **Gender**: _____

Address:_____

	May we Contact?	**Preferred?**	**Message?**
Mother's E-mail: _____	☐	☐	
Father's E-mail: _____	☐	☐	
Home Phone: _____	☐	☐	☐
Mother's Cell Ph: _____	☐	☐	☐
Father's Cell Ph: _____	☐	☐	☐
Mother's Work Ph: _____	☐	☐	☐
Father's Work Ph: _____	☐	☐	☐

Spoken Language: □ English □ Spanish □ Other

Primary Care Physician: _____ **Other Specialist:** _____

Primary Insurance Co: _____

Name of Insured/Subscriber: _____ Date of Birth: _____

Address of Insured (if different): _____

Member ID: _____ Group/Plan Number: _____

Secondary Insurance Co: _____

Name of Insured/Subscriber: _____ Date of Birth: _____

Address of Insured (if different): _____

Member ID: _____ Group/Plan Number: _____

We will make a copy of the front and back of your insurance card(s)

Current Medications or Provide List_____

_____

_____