peekaboo pediatrics

MOTHER-DAUGHTER TEAM OF

HEENA N. THAKKAR, MD, FAAP & SHILPA T. PANKAJ, MD, FAAP

PATIENT INFORMATION

Child's Legal Name: (Last, First, Middle)	**DOB:** (M/D/Y)	**Sex:** M F	**Preferred Name:**
Other Children in Family:		**Home Phone #:**	
Street Address:	**City:**	**State:**	**Zip:**
Primary Phone #: (phone # you wish to receive appointment reminders, updates, etc.)	**Primary Email Address:** (email you wish to receive appointment reminders, updates, etc.)		
Language: (Circle please) English Spanish Other:____________________	**Race:** (Circle please) American Indian Black/African American Other: ____________ Asian White Pacific Islander Hispanic		
Hospital at which patient was born:	**Did Dr. Thakkar or Dr. Pankaj see the patient in the newborn nursery?** Yes No		
How did you hear about or find us?			

EMERGENCY CONTACT INFORMATION

Mom's Name: (Last, First, Middle)	**Mom's Cell #:**		**Mom's Work #:**
Mom's Occupation:	**Mom's Email address:**		
Mom's Street Address: (if different from patient)	**City:**	**State:**	**Zip:**
Dad's Name: (Last, First, Middle)	**Dad's Cell #:**		**Dad's Work #:**
Dad's Occupation:	**Dad's Email address:**		
Dad's Street Address: (if different from patient)	**City:**	**State:**	**Zip:**
Parent's Marital Status: (circle please) Married Single Separated Divorced Widowed			

Other Emergency Contact:	Relation to Patient:	Emergency Contact #:

GUARANTOR INFORMATION (person financially responsible)

Name:	Date of Birth:	Relationship to Patient:	
Street Address:	**City:**	**State:**	**Zip:**
SSN:	**Home #:**	**Cell #:**	**Work #:**

INSURANCE INFORMATION

Primary Insurance

Insurance Name:	Insurance Telephone #:	
Subscriber Name:	**Subscriber DOB:**	**Subscriber SSN:**
Subscriber ID#:	**Group #:**	**Subscriber Employer:**

Secondary Insurance (if applicable)

Insurance Name:	Insurance Telephone #:	
Subscriber Name:	**Subscriber DOB:**	**Subscriber SSN:**
Subscriber ID#:	**Group #:**	**Subscriber Employer:**

PHARMACY INFORMATION

***Please note that Peekaboo Pediatrics sends all of our prescriptions electronically, and you will be required to choose a pharmacy which accepts electronic prescriptions. If at any point you wish to change your pharmacy, you must do so BEFORE the physician sees your child for an appointment that day.*

Pharmacy Name:	Pharmacy Phone Number:	Pharmacy Fax Number:	
Pharmacy Street Address:	**City:**	**State:**	**Zip:**