RIVIERA PEDIATRICS 4115 OFFICE PLAZA BLVD INDIANAPOLIS, IN 46254

Patient Name:_____Birth Date:_____ Date First Seen:_____

Father's Name:_____ Mother's Name:_____
Father's Address:_____ Mother's Address:_____
Father's City & Zip: _____ Mother's City & Zip:_____
Father's Daytime Phone: _____ Mother's Daytime Phone:_____
Father's Cell Phone: _____ Mother's Cell Phone:_____
Referred by: _____

BIRTH INFORMATION

Term__ Preemie__ Vaginal Delivery__ C Section__ Sex__ Birth Weight____ Feeding: Breast__ Formula__

FAMILY HISTORY

Please check if any member of your family had one of these diseases as a child.

Seizures__ Diabetes__ Mental Retardation__ High Blood Pressure__ Heart Disease__ Other_____

IMMUNIZATIONS

Hep B					**Hep A**		
T/dap							
DTaP							
HIB							
Polio							
Pneumococcal							
MMR							
Varicella							
Rotovirus							
Hpv							
Meningococccal							
Flu							
Other							

ALLERGIES

Medicine/Allergen	Reaction
1.	
2.	
3.	
4.	
5.	

LIST PREVIOUS ILLNESS OR SURGERIES

_____

_____

_____

Doctor_____

RIVIERA PEDIATRICS
4115 Office Plaza Boulevard
Indianapolis, IN 46254
317-297-3507

Patient's Name_____ Sex_____ DOB_____/_____/_____

Patient's Name_____ Sex_____ DOB_____/_____/_____

Patient's Name_____ Sex_____ DOB_____/_____/_____

Patient's Name_____ Sex_____ DOB_____/_____/_____

Patient's Name_____ Sex_____ DOB_____/_____/_____

Address_____

City_____ State_____ Zip_____

Home Phone_____-_____-_____ Mother's Cell_____-_____-_____

Father's Cell_____-_____-_____

Mother's Full Name_____

Mother's SSN_____ Mother's DOB_____

Mother's DLN_____ Expiration_____

Mother's Employer_____ Work #_____

Father's Full Name_____

Father's SSN_____ Father's DOB_____

Father's DLN_____ Expiration_____

Father's Employer_____ Work#_____

Responsible Party's Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____-_____-_____ Cell_____-_____-_____

_____ _____

Signature of Responsible Party or Patient if over the age of 18 Date

INSURANCE FORM

PRIMARY INSURANCE- We require a copy of your current insurance card

Insurance Company_____

Insurance Company Address_____

City_____State_____Zip_____

Policy Holder's Name_____

Policy Holder's SSN_____-_____-_____ DOB_____/_____/_____

Policy Holder's Employer_____

Effective Date_____/_____/_____ End Date_____/_____/_____CoPay_____

ID#_____Group#_____

SECONDARY INSURANCE-Riviera Pediatrics will only file with the following secondary insurance companies: Anthem BCBS, Children's Special Health Care, and Medicaid. Other secondary insurances will have to be filed by the policy holder.

Insurance Company_____

Insurance Company Address_____

City_____State_____Zip_____

Policy Holder's Name_____

Policy Holder's SSN_____-_____-_____ DOB_____/_____/_____

Policy Holder's Employer_____

Effective Date_____/_____/_____ End Date_____/_____/_____CoPay_____

ID#_____Group#_____

I request that payment of authorized benefit be made on my behalf for any services rendered to me by Riviera Pediatrics including the Physicians' services. I authorize any holder of medical or other information about me to release to the healthcare financing administration, its agents or other health carriers the information as needed to determine these benefits for related services.

_____ Date_____

Signature of Responsible Party