Rainbow Pediatrics

153 West Main St., Suite 200
New Albany, OH 43054

6905 Hospital Dr., Suite 100
Dublin, OH 43016

How were you referred to our office? _____

Physician your child would like to see primarily: _____

Please complete for the patient being seen today:
Last Name: _____
First Name: _____
Nick/Preferred Name: _____
Child lives with _____
Date of Birth: _____
Sex: Male Female
Languages spoken at home: _____

Name/DOB/Sex of Siblings:
_____
_____
_____
_____

Insurance Information: (Please be ready to show card at each visit)
Primary Insurance Name: _____
Primary Insurance ID Number: _____
Primary Insurance Group Number: _____
Mailing Address for Claims: _____
_____
Policy Holder Name: _____
Policy Holder Date of Birth: _____

Secondary Insurance Information: (Please be ready to show card at each visit)
Secondary Insurance Name: _____
Secondary Insurance ID Number: _____
Secondary Insurance Group Number: _____
Mailing Address for Secondary Claims: _____
_____
Secondary Policy Holder Name: _____
Secondary Policy Holder Date of Birth: _____
Policy Holder SSN: _____

Guardian: Please complete the following information for the parent/guardian who does NOT hold the primary insurance.
Last Name: _____
First Name: _____
Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: (_____) _____ ☐ Preferred Contact Number
Home/ Land Line Phone: (_____) _____ ☐ Preferred Contact Number
SSN: _____ Date of Birth: _____
Occupation / Skill / Trade: _____

Guarantor: Please complete the following information for the parent/guardian who holds the primary insurance.
Last Name: _____
First Name: _____
Relationship to Patient: _____
Address _____
City: _____ State: _____ Zip: _____
Cell Phone: (_____) _____ ☐ Preferred Contact Number
Home/ Land Line Phone: (_____) _____ ☐ Preferred Contact Number
SSN: _____ Date of Birth: _____
Occupation / Skill / Trade: _____

Emergency contact:
Name: _____ Relation to Patient: _____
Preferred Contact Number: (_____) _____

Authorization: Provided proper photo identification is shown, I give the following person/people authority to make medical decisions for my child(ren) in my absence.
_____
_____
_____

I certify the above is correct: _____ Date: _____
Signature of Parent/Guardian completing form