Natural Pediatric Medicine, LLC – Dr. Robin Russell

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(860) 909-1082 – Phone • (860) 379-0876 – Fax

Patient Information

Date:_____

Last Name:_____First Name:_____Middle Name:_____

Date of Birth:_____Sex:_____Age:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_(_____)_____Work Phone:_(_____)_____Cell Phone:_(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? □ No □ Yes
(Specify): □ Home □ Work □ Cell

Email:_____Emergency Contact/Relation:_____Contact's Phone:_____

Referral Source: □ Referred by:_____ □ Insurance Provider List
□ Internet (CNPA OR PedANP website) □ Physician's Website □ Other _____

Employer:_____ Occupation:_____

Mother's Name (Minor's only):_____Father's Name (Minor's only):_____

Benefits and Billing Information

I. Primary Insurance Company & Plan Name:_____

ID Number:_____Group/Policy #_____

Name of Policy Holder:_____Policy Holder's Date of Birth:_____

Relationship to Policy Holder:_____Is Your Primary Insurance Policy: □ POS □ PPO □ EPO □ HMO

II. Does your insurance have alternative medicine benefits? □ Yes □ No

Who is your Primary Care Provider? _____ Clinic Phone: _(_____)_____

Clinic Address: _____City:_____State:_____Zip Code:_____

Does your plan require you to have a referral from your Primary Care Provider to receive coverage? □ Yes □ No

If yes, which licensed provider were you referred by to our clinic? _____