



# Ennis Pediatric and Adolescent Health Care Center, P.A.

Katherine Witte, M.D. • 2203 West Lampasas Street, Suite 202, Ennis, Texas, 75119 • 972-875-8300

## PATIENT GENERAL INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DRIVER LICENSE NUMBER & ISSUING STATE (IF APPLICABLE)	
STREET ADDRESS		CITY, STATE, ZIP CODE	
HOME PHONE	CELL PHONE (13 AND OLDER)	E-MAIL ADDRESS (13 AND OLDER)	
RACE	ETHNIC GROUP	LANGUAGE	

## PARENT INFORMATION

FATHER'S NAME	DATE OF BIRTH	DRIVER LICENSE NUMBER & ISSUING STATE
STREET ADDRESS	CITY, STATE, ZIP CODE	
HOME PHONE	CELL PHONE	WORK PHONE
EMPLOYER	E-MAIL ADDRESS	
MOTHER'S NAME	DATE OF BIRTH	DRIVER LICENSE NUMBER & ISSUING STATE
STREET ADDRESS	CITY, STATE, ZIP CODE	
HOME PHONE	CELL PHONE	WORK PHONE
EMPLOYER	E-MAIL ADDRESS	

## EMERGENCY INFORMATION

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT
HOME PHONE	CELL PHONE
	WORK PHONE

## INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	PHONE
CLAIMS MAILING ADDRESS	
NAME OF PRIMARY INSURED OR POLICY OWNER	PATIENT ID NUMBER
POLICY NUMBER	GROUP NUMBER
	EFFECTIVE DATE



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## PREFERRED PHARMACY

PHARMACY NAME AND LOCATION	PHARMACY PHONE
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## CORRESPONDENCE PREFERENCES

MAY WE CALL YOUR <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone ?	MAY WE CONTACT YOU BY E-MAIL? <input type="checkbox"/> Yes <input type="checkbox"/> No
WHAT IS YOUR PREFERRED CORRESPONDENCE WITH OUR OFFICE? <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> E-mail	
MAY WE LEAVE MESSAGES ON YOUR <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone ?	
HOW DID YOU HEAR ABOUT US, OR WHOM MAY WE THANK FOR YOUR REFERRAL?	