

*Welcome  
to our practice!*

**CHILD CARE CONSULTANTS, INC.**

**WEST OFFICE**  
111 INAH AVE.  
COLUMBUS, OHIO 43228  
(614) 878-6415

**NORTH OFFICE**  
5957 CLEVELAND AVE., SUITE A  
COLUMBUS, OHIO 43231  
(614) 523-1666

**PATIENT INFORMATION**

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex:  M  F Have any of your children ever  
been seen by CCCI Providers before?  Yes  No Whom? \_\_\_\_\_  
In case of emergency, whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ (Nearest friend/relative NOT living with you)

**MOTHER'S INFORMATION**

Mother's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**FATHER'S INFORMATION**

Father's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I authorize the above doctor and/or any provider or supplier of services in this office to use and/or disclose any protected health information required to carry out treatment and health care operations and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

May we leave a message at your home with other residents?  Yes  No  
May we leave a message on your answering machine/voice mail?  Yes  No  
Can we communicate with you via the Internet?  Yes  No E-mail address \_\_\_\_\_

Who may we talk to about your medical concerns other than the biological parents? \_\_\_\_\_  
Is this contact only for emergency purposes?  Yes  No, you can talk to this person whenever needed.

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please provide photo ID and proof of medical coverage with return of this form to our receptionist.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_