Youngblood Pediatrics|
7525 Greenway Center Dr. Suite 311
Greenbelt, MD 20770| 301-441-4555

New Patient Intake Form

Date:_____

First name:_____ Middle name:_____ Last name:_____

DOB:_____ Age:____ Sex: M/F SSN:_____

Street address:_____ City: _____State: _____

Zip:_____ Phone number: _____

Parent/Guardian Contact Information:

Name: _____ Relationship: _____ Phone: _____

Email address: _____ Parent DOB: _____ SSN:_____

Emergency Contact Information (*in the event parent or guardian can't be reached*)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Previous Physician:_____ Phone Number:_____

PLEASE CONTACT YOUR PREVIOUS PHYSICIAN TO HAVE YOUR RECORDS FAXED TO US.
FAX: 301-441-3420

Primary Insurance:	**Secondary Insurance:**
Insured Name:	
DOB of policy holder:	
Policy/Member ID number:	
Relationship: Self Dependent	

Medical claims address (back of card):

Medical claims phone number:

IF YOU HAVE PRIVATE INSURANCE IN ADDITION TO MEDICAID,
Please include a copy of the front and back of the insurance card. YOU MUST DISCLOSE THE POLICY NUMBERS FOR BOTH THE PRIVATE INSURANCE AND MEDICAID.