



# The Pediatric Care Center, LLC

Susan Adeyinka, MD, FAAP

Child's Name(s)

Date(s) of birth

SS#

_____	_____	_____
_____	_____	_____
_____	_____	_____

## Guardian Information: Mother

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Phone \_\_\_\_\_ Ext \_\_\_\_\_

## Guardian Information: Father

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Phone \_\_\_\_\_ Ext \_\_\_\_\_

## Insurance Information: Primary

Company \_\_\_\_\_ ID# \_\_\_\_\_  
Address \_\_\_\_\_  
Who's name is insurance under?  
\_\_\_\_\_

## Insurance Information: Secondary

Company \_\_\_\_\_ ID# \_\_\_\_\_  
Address \_\_\_\_\_  
Who's name is insurance under?  
\_\_\_\_\_

## In an emergency, who is to be notified (other than parent)?

Name \_\_\_\_\_ Phone \_\_\_\_\_

I hereby authorize payment of all medical benefits to:  
Susan Adeyinka, M.D.

Signature \_\_\_\_\_ Date \_\_\_\_\_