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Patient and Family Information

Child 1: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 2: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 3: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 4: Last Name: _____ First Name: _____ MI: _____
DOB: ____/____/____ Sex: M / F Preferred Language: _____
Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian
☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 5: Last Name: _____ First Name: _____ MI: _____
DOB: ____/____/____ Sex: M / F Preferred Language: _____
Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian
☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 6: Last Name: _____ First Name: _____ MI: _____
DOB: ____/____/____ Sex: M / F Preferred Language: _____
Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian
☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 7: Last Name: _____ First Name: _____ MI: _____
DOB: ____/____/____ Sex: M / F Preferred Language: _____
Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian
☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Pharmacy Name: _____ Pharmacy Phone #: _____

Parent/Legal Guardian #1:

Child(ren)'s parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widow(er) ☐ Other

Name: _____ Relationship to Patient: _____

DOB: ____/____/____ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____

Best number to reach me is: ☐ Home ☐ Cell ☐ Work

Living Well Pediatrics, PC, may contact me via: ☐ Home ☐ Cell ☐ Work ☐ Email

Living Well Pediatrics, PC, may leave messages or lab results via: ☐ Home ☐ Cell ☐ Work ☐ Email

Lives with patient? Yes / No

(Street)

(City/State/Zip)

Parent/Legal Guardian #2:

Name: _____ Relationship to Patient: _____

DOB: ____/____/____ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____

Best number to reach me is: ☐ Home ☐ Cell ☐ Work

Living Well Pediatrics, PC may contact me via: ☐ Home ☐ Cell ☐ Work ☐ Email

Living Well Pediatrics, PC may leave messages or lab results via: ☐ Home ☐ Cell ☐ Work ☐ Email

Lives with patient? Yes / No
Parent/Legal Guardian #1):

If you do not live with the patient, please provide the address (please disregard if same as

(Street)

(City/State/Zip)

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient’s records? Yes / No

If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child’s medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Emergency Contacts, other than parents. Name & Relationship:

Name: _____ Phone: _____

Name: _____ Phone: _____