



4986 N Adams Rd, Suite B  
Oakland Township, MI 48306  
Tel: (248)-609-1800  
Fax: (248)-278-4977

**Patient and Family Information:**

**Today's Date:** \_\_\_\_\_

Pt Name \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M/F

**Birth History:** Gestational age at birth: Weeks \_\_\_\_\_ Days \_\_\_\_\_

**Multiple Birth:** Yes/No If answer is yes what number was patient \_\_\_\_\_

Siblings: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
\_\_\_\_\_ D.O.B. \_\_\_\_\_  
\_\_\_\_\_ D.O. B \_\_\_\_\_  
\_\_\_\_\_ D.O. B \_\_\_\_\_

**Race:** African American American Indian or Native Alaskan White Other \_\_\_\_\_ Decline

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

**Preferred Language** \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

**Parent/Legal Guardian:**

Child(ren)'s parents are: Married Divorced Never Married Separated Widow Other \_\_\_\_\_

**Parent/Guardian #1:** Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Email: \_\_\_\_\_  
Lives with patient? Yes/No  
Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Preferred Method of contact:  
Monarch Pediatrics may leave messages or lab results via: Home Cell Work Email  
Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

**Parent/Guardian #2:** Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Email: \_\_\_\_\_  
Lives with patient? Yes/No  
Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Preferred Method of contact:  
Monarch Pediatrics may leave messages or lab results via: Home Cell Work Email  
Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

**Insurance and Billing Info:**

Insurance Carrier \_\_\_\_\_ ID Number \_\_\_\_\_ Group# \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship to patient \_\_\_\_\_



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**Emergency Contacts:** (other than parents/legal guardian)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

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

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

Who has primary 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(ren)'s medical treatment? Yes / No

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

Who should receive billing statements? \_\_\_\_\_