KIDS FIRST PEDIATRICS

growing families one kid at a time

New Patient Intake Form

Children:

Name (Last, First)_____ Date of Birth:_____
Name (Last, First)_____ Date of Birth:_____
Name (Last, First)_____ Date of Birth:_____
Name (Last, First)_____ Date of Birth:_____

Mailing Address:

Street:_____

City: _____ State:_____ Zipcode:_____

Household Contacts:(*please list all adults your child lives with and their relationship to your child*)

Name of Family Member	Relation to Patient	Biological relation? (Y/N)	DOB	Phone Number and email (if applicable)

Notification Preferences:

1. Who should be contacted for Appointment Reminders? _____
2. Do you prefer reminders and notifications via Text, Call, or Email? _____