

GENERAL INFORMATION



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

D.O.B.: ____/____/____ Sex: M / F Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Pac Island/ White/ Nat Amer/AK Native

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

D.O.B.: ____/____/____ Sex: : M / F Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Pac Island / White/ Nat Amer/AK Native

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

D.O.B.: ____/____/____ Sex: : M / F Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Pac Island / White/ Nat Amer/AK Native

Mailing Address:

(Street or PO Box)

(City)

(State & Zip)

Preferred Phone: (_____) _____ - _____

Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Date of Birth: ____/____/____

Insurance Carrier: _____

ID# _____ Group # _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: ____/____/____

Insurance Carrier: _____

ID# _____ Group # _____

Guardian 1: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____ Primary Language: _____

Preferred Phone: (____) ____ - ____ Home /Cell Do you want access to portal? Yes/No

Preferred Email: _____ Biological parent: Yes / No

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (circle ONE):

Appointment Reminders: Phone / Email / Text to Cell

Guardian 2: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____ Primary Language: _____

Preferred Phone: (____) ____ - ____ Cell/Home Do you want access to portal? Yes/No

Preferred Email: _____ Biological Parent Yes / No

Employer: _____ Occupation: _____

Will this contact need to be notified in addition to Contact 1? (If yes, How would you ideally prefer to be contacted regarding (circle ONE):

Appointment Reminders: Phone / Email / Text to Cell

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Additional Contact Questions:

Who should receive billing statements? _____

May both contacts 1 and 2 have access to the patient's records electronically? Yes / No / _____

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

Who has legal 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/ guardians: Name & Relationship

1: _____ / _____ Phone: (_____) _____ - _____
(Name) (Relation)

Does contact have consent to make medical decisions if escorting patient to an appointment? Yes/No

2: _____ / _____ Phone: (_____) _____ - _____
(Name) (Relation)

Does contact have consent to make medical decisions if escorting patient to an appointment? Yes/No

How did you hear about us? _____