Pediatrics, PC

To be completed by custodial parent or legal guardian only.
Type information directly into the form and print, (or print and fill out by hand.) Sign and bring to your appointment.

** **Is there a court order for any of your children regarding legal, financial, or physical custody?** _____

(If answered yes, please discuss with receptionist as we may need a copy of the document)

Today's Date: _____

Mother (Last, First, Middle Initial)

Name _____
DOB _____ Marital Status Single
Name of spouse _____
Home address _____
City _____ State _____ Zip _____
Employer _____
Occupation _____
SSN _____
Phone #'s Home _____
Cell _____ Work _____
***e-mail appointment reminders? □ YES □ NO
email _____

Father (Last, First, Middle Initial)

Name _____
DOB _____ Marital Status _ Single
Name of spouse _____
Home address _____
City _____ State _____ Zip _____
Employer _____
Occupation _____
SSN _____
Phone #'s Home _____
Cell _____ Work _____
***e-mail appointment reminders? □ YES □ NO
email _____

CHILDREN WHO RECEIVE CARE HERE:

Last Name	First Name	MI	M / F	DOB	Primary Address	Cell Ph# (If teenager)
			M			
			M			
			M			
			M			
			M			

INSURANCE (Attach copy of cards)

#	Subscriber's Name	Sub DOB	Rel. to child	Insurance Co Name	Contract, Policy or ID #	Group #	Co-Pay Amt?
1							
2							
3							

WHOM DO YOU AUTHORIZE TO OBTAIN MEDICAL CARE OR DISCUSS MEDICAL ISSUES FOR YOUR CHILDREN?

Name	Relationship to child	Phone #

If your child is 16 or older, can they be seen without a parent or authorized adult being present? ☐YES ☐NO ☐Only with a note from me

Emergency Contact (not a parent) _____
Name Relationship to child Phone Number

I hereby authorize the release of pertinent medical information for all children listed above for the purposes of obtaining payment, treatment, or other health care operations.

_____
Parent's signature Date