Child's name _____ DOB _____ Sex: M☐ F☐

Address _____ City_____ State_____ Zip_____

Language preference: English☐ Spanish☐ Other☐_____ Race _____ Ethnicity _____

Names and date of birth of siblings also seen here: _____

Father's name _____

DOB _____ Driver's lic # _____

Address _____

City_____ State_____ Zip_____

Tele #: home _____ work _____

cell _____ E-mail _____

Employer _____

Occupation _____

Mother's name _____

DOB _____ Driver's lic # _____

Address _____

City_____ State_____ Zip_____

Tele #: home _____ work _____

cell _____ E-mail _____

Employer _____

Occupation_____

Parent marital status _____ If single or divorced, with whom does child live? _____

Name of legal guardian(s) if other than parents _____

Name and telephone # emergency contact (other than parent) _____

Whom may we thank for referring you to our office? _____

Primary Insurance information:

(If secondary insurance applies, please provide information along with paperwork.)

Name of policy holder _____ Relationship to patient _____

Insurance company _____ Policy #_____ Group # _____

Address _____ City_____ State_____ Zip_____

For office use only:

Date _____ *Patient #* _____ *PCP* _____