PATIENT DEMOGRAPHICS DATABASE

Please help us serve you well by listing as much information as possible!

Child's Legal Name _____ DOB _____

Lives with _____ Insured Parent _____ Insured Parent _____

Child's Legal Name _____ DOB _____

Lives with _____ Insured Parent _____ Insured Parent _____

Child's Legal Name _____ DOB _____

Lives with _____ Insured Parent _____ Insured Parent _____

Child's Legal Name _____ DOB _____

Lives with _____ Insured Parent _____ Insured Parent _____

Parent Name _____ Relationship _____

Address _____

City _____ Zip _____ Home phone _____

Work phone _____ Cell phone _____ Pager _____

email _____ Parent DOB _____

Parent Name _____ Relationship _____

Address _____

City _____ Zip _____ Home phone _____

Work phone _____ Cell phone _____ Pager _____

email _____ Parent DOB _____

Emergency Contact (not living in home) _____

_____

I am the parent/legal guardian of the above named child/children. I give consent for routine and emergency medical treatment for my children named above, including, but not limited to well child care and vaccinations, administration of antibiotics, routine lab tests and x-rays, and other diagnostic or therapeutic procedures reasonably necessary for my child's/children's health.

Signature _____ Date _____

For Office Use Only

Reviewed:

Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____

Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____