Welcome!

ABOUT YOUR CHILD	FAMILY INFORMATION
Today's Date: / /	Parent's Marital Status:
Child's Name:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Child's Nickname: ☐F ☐ M	
Birth Date: / / Current Age:	Mother's Name:
Child's Home Address:	☐ Biological ☐ Step Mother ☐ Guardian
	Mother's current physical health is:
City: State: Zip:	☐ Good ☐ Fair ☐ Poor
Child Resides With:	Birth date: / / Home Phone:
	Employer: Work Phone:
Referred by:	Social security #:

WHO IS ACCOMPNYING THIS CHILD TODAY	Father's Name:
Name:	☐ Biological ☐ Step Father ☐ Guardian
Relation:	Father's current physical health is:
Are you the legal guardian of this child?	☐ Good ☐ Fair ☐ Poor
☐ Yes ☐ No	Birth date: / / Home Phone:
	Employer: Work Phone:
YOUR CHILD'S MEDICAL HISTORY	Social security #:
List any allergies your child has:	
	Who is responsible for making appointments?
	☐ Mother ☐ Father
List current medications prescription/over the counter:	Name:
	Home Phone:
	Work Phone:

List previous surgeries/treatments with date:	Please list all other family members residing at current address: (including gender & birth date)
Has your child had any of the following illnesses? Measles ☐ German Measles ☐ Mumps ☐ Scarlet Fever ☐ Chicken Pox ☐ Cancer ☐ Pneumonia ☐ Urinary Tract Infection ☐ HIV/AIDS ☐ Rheumatic Fever ☐ Diabetes ☐ Tuberculosis ☐ Other Illnesses:_____	

INSURANCE INFORMATION

Primary Insurance Co.

Name:	ID No.:
Address:	Group No.:
Phone:	
Insured's Name:	Insured's SS#:
Birth Date:	Relation:
Insured's Employer	

Secondary Insurance Co.

Name:	ID No.:
Address:	Group No.:
Phone:	
Insured's Name:	Insured's SS#:
Birth Date:	Relation:
Insured's Employer	

In the event of an emergency whom should we contact?

Name:	Relation:
Work Phone:	Home Phone:

ACCOUNT INFORMATION

Person Responsible for Account

Name:	Relation:
Billing Address:	City: State: Zip:
Home Phone:	Work Phone:
SS#:	Drivers Lic. No.:

We invite you to discuss frankly with us any questions regarding our services. The best health services are those based on a friendly, mutual understanding between provider, parent and patient.

I understand the above information, guarantee this form was completed correctly to best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Responsible Person Date: