Children's Clinic Patient Information

Child Information:

First Name	*Middle*	*Last Name*	*M or F*	*Date of Birth*

Email Address *With Whom Does the Child Reside? (Mother, Father, Both)*

Mother/Guardian Name *Date of Birth* *Home Phone* *Cell Phone*

Mother/Guardian Mailing Address

Employment Status/ Employer/ Work Number

Father/Guardian Name *Date of Birth* *Home Phone* *Cell Phone*

Father/Guardian Mailing Address

Employment Status/ Employer/ Work Number

Additional Emergency Contact Information (Optional): Name/DOB/Phone Number/Relation to patient

Primary Medical Insurance *Policy Holder Name/ Date of Birth/SSN*

Policy ID# *Group #* *Relationship to Patient*

Secondary Medical Insurance *Policy Holder Name/Date of Birth/SSN*

Policy ID# *Group #* *Relationship to Patient*

Choose One:

Race: White ~ Black ~ Asian ~ Native American ~ Other ____

Ethnicity/Nationality: Non-Hispanic ~ Hispanic

Preferred Language: English ~ Spanish ~ Other ____

*Reminder Call Preference: Automated Voice Message ~ Text Message, Preferred Number*__________________________

Signature and Date ____