

Welcome

Patient Information

_____ Child's Name		_____ Nickname		M _____	F _____
_____ Child's Birthdate	_____ School	_____ Child's Home Street Address			
_____ Child's Home Phone #		_____ City	_____ State	_____ Zip	

Parent/Guardian Information

_____ Name of Person Completing Paperwork		_____ Relationship to Child			
_____ Who has legal custody of the child?					
_____ Parent/Guardian Name			_____ Parent/Guardian Name		
_____ M _____ F _____			_____ M _____ F _____		
_____ Relationship to Child			_____ Relationship to Child		
_____ Home Phone #	_____ Cell Phone #	_____ Home Phone #	_____ Cell Phone #		
_____ Work Phone #	_____ Occupation	_____ Work Phone #	_____ Occupation		
_____ Employer			_____ Employer		
_____ Email			_____ Email		
_____ S.S. #	_____ Birthdate	_____ S.S. #	_____ Birthdate		
<input type="checkbox"/> Check here if address same as child's OR indicate below			<input type="checkbox"/> Check here if address same as child's OR indicate below		
Address: _____			Address: _____		
_____ Parent's/Guardian's Martial Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Domestic Partners ___					

Family Information

Is your child adopted? Yes ___ No ___

Other family members seen here: _____

Who does the child live with? _____

Whom may we thank for referring you: _____

How can we best contact you: Phone _____ Email _____ Text _____

Can we email you office newsletters and event invitations? Yes _____ No _____

Primary Insurance

Secondary Insurance

_____ Subscriber's Name		_____ Subscriber's Name	
_____ Insurance Co.	_____ State	_____ Insurance Co.	_____ State
_____ Subscriber ID	_____ Group #	_____ Subscriber ID	_____ Group #
_____ Subscriber Date of Birth	_____ Insurance Co. Phone #	_____ Subscriber Date of Birth	_____ Insurance Co. Phone #