OFFICE USE ONLY:

ACCT#

☐ FIN POL: 2017

Pediatrics, PC

FAMILY INFORMATION SHEET

Today's Date: ____________________

****To be completed by custodial parent(s) only. Complete all areas. Please print clearly.****

Is there a court order for any of your children regarding legal, financial, or physical custody? ☐No ☐Yes

(If answered yes, please discuss with receptionist as we may need a copy of the document)

Mother

Name ____________________

DOB ____________________ Marital Status S M D W

Name of spouse ____________________

Home address ____________________

City ____________________ Zip ____________

Employer ____________________

Occupation ____________________

SSN ____________________

Home Ph# ____________________

Cell ____________________ Work ____________________

******e-mail appointment reminders? ☐ YES ☐ NO***

email ____________________

Father

Name ____________________

DOB ____________________ Marital Status S M D W

Name of spouse ____________________

Home address ____________________

City ____________________ Zip ____________

Employer ____________________

Occupation ____________________

SSN ____________________

Home Ph# ____________________

Cell ____________________ Work ____________________

******e-mail appointment reminders? ☐ YES ☐ NO***

email ____________________

CHILDREN WHO RECEIVE CARE HERE:

Last Name	First Name	MI	M / F	DOB	Primary Address	Cell Ph# (If teenager)

INSURANCE (Attach copy of cards)

#	Subscriber's Name	Sub DOB	Rel. to child	Insurance Co Name	Contract, Policy or ID #	Group #	Co-Pay
1							$
2							$
3							$

OTHERS AUTHORIZED TO OBTAIN MEDICAL CARE OR DISCUSS MEDICAL ISSUES FOR YOUR CHILDREN?

Name	Relationship to child	Phone #

*****If your child is 16 or older, can they be seen without a parent or authorized adult being present? ☐YES ☐NO ☐Only with a note from me*****

Emergency Contact (not a parent) ____________________

Name Relationship to child Phone Number

I hereby authorize the release of pertinent medical and insurance information for all children listed above for the purposes of obtaining payment, treatment, or other health care operations.

____

Parent's signature Date