CHILD'S LAST NAME _____ **FIRST NAME** _____ **MI** _____

DATE OF BIRTH _____/_____/_____ **SEX** _____M _____F **EMAIL** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PCP _____

PHARMACY _____ **ADDRESS** _____

RACE

__American Indian or Alaska Native __Asian __Native Hawaiian or Other Pacific Islander __Other Race

__Black or African American __White __Hispanic __Refused to Report

ETHNICITY: __Hispanic or Latin __Not Hispanic or Latin __Refused to Report

LANGUAGE: __English __Spanish __Other: _____

PREFERRED METHOD OF CONTACT: ___ Phone ___Letter ___Both

HOME PHONE: _____ **CELL PHONE:** _____

At which of these phone numbers may we leave a message? ___Home ___Cell

PRIMARY INSURANCE NAME _____ **ID#** _____

SECONDARY INSURANCE NAME _____ **ID#** _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? __Family/Friend __Doctor __Hospital __Internet __Facebook

PARENT/GUARDIAN (*Full Name*)_____

RELATIONSHIP TO CHILD _____ DATE OF BIRTH _____

SOC. SEC #_____ EMAIL _____

ADDRESS (*If different from child*)_____

PARENT/GUARDIAN (*Full Name*)_____

RELATIONSHIP TO CHILD _____ DATE OF BIRTH _____

SOC. SEC #_____ EMAIL _____

ADDRESS (*If different from child*)_____

EMERGENCY CONTACT (*Full Name*)_____PHONE #_____

OTHER CHILDREN IN FAMILY

Name_____DOB_____ Name_____DOB _____

Name_____DOB_____ Name_____DOB _____

I authorize the release of all medical information necessary to process claims for covered services rendered by Village Pediatrics. I authorize Village Pediatrics to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Village Pediatrics. A copy of this authorization may be used in place of the original. I give permission for Village Pediatrics to obtain my child's medication history from my pharmacy, my health plan(s) and other healthcare providers for the purpose of electronic prescribing and continuity of care.

Signature_____ Date _____