**FAMILY INFORMATION** **DATE COMPLETED: _____**

***Thank you for choosing our office. In order to serve you properly, we need the following information. Please PRINT and fill out this form completely.***

Parent's Name: _____ Parent's Name: _____

Street Address: _____

City_____ State_____ Zip_____

Primary Phone Number: _____

Primary E-mail Address: _____

Preferred method for appointment reminder (please check one): Text_____ _ Email_____ Phone_____

***CHILDREN: (please fill out sex according to insurance)***

1._____ DOB: _____ M / F / Identifies as:_____

2._____ DOB:_____ M / F / Identifies as:_____

3._____ DOB: _____ M / F / Identifies as:_____

4._____ DOB:_____ M / F / Identifies as:_____

5._____ DOB:_____ M / F / Identifies as:_____

6._____ DOB:_____ M / F / Identifies as:_____

***PARENT***: DOB: _____ Identifies as:_____

First and Last Name : _____

Occupation: _____

Employed by: _____

Work Number_____ Cell Number _____

***PARENT***: DOB_____ Identifies as:_____

First and Last Name: _____

Occupation: _____

Employed by: _____

Work Number_____ Cell Number _____

***Parent or Guardian (if applies):*** _____

Home Number:_____ Cell Number:_____

***OTHER PHONE NUMBERS:***

Caretaker Name:_____ Phone Number:_____

Day Care Name: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

***INSURANCE INFORMATION:***

Primary Insurance Policy Holder's Name: _____

Primary Insurance Policy Holder's DOB: _____

Insurance Company: _____

ID Number: _____

Group Number: _____

Deductible Amount: _____ Co-Pay Amount: _____

***ATTESTATION:***

**Parents are expected to attend all wellness visits until patients reach the age of 18.**

During the first 3 years of life, we see infants for routine well childcare at:
**1 month**, **2 months**, **3 months**, **4 months**, **5 months**, **6 months**, **7 months**, **9 months**, **12 months**, **15 months**, **18 months**, **2 Years**, **2 ½ years**, **3 years**, and **annually** thereafter.

**Please verify that your insurance company provides full coverage for these visits prior to the visit.**
***If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.***

Signature
(Parent or Legal
Guardian)_____Date:_____

**Pediatrics on Hudson follows the immunization schedule set forth by the American Academy of Pediatrics. Please refer to www.aap.org for details. We firmly believe in the effectiveness of vaccines to prevent serious illness and that they are crucial to every child's health. If you choose not to vaccinate your child, we ask you to find a different pediatric practice to care for your child**.

Signature
(Parent or Legal Guardian)_____Date:_____