Patient's First Name	Patient's Last Name	DOB	Sex	Preferred Language	Ethnicity (Hispanic or Non-Hispanic)	FRONT OFFICE USE ONLY
1.						Scanned
2.						Initials
3.						
4.						

PLEASE NOTE: *Federal regulations require electronic medical records providers to ask your race and ethnicity.*

RACE: (please circle one) **American Indian** **Native Hawaiian** **Black or African American** **Asian** **More than 1 race** **Alaska Native** **Other Pacific Islander** **White**

Child Lives With: ☐ **Father** ☐ **Mother** ☐ **Both Parents** ☐ **Guardian**	
Father's Name:	**Mother's Name:**
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone: Cell:	Phone: Cell:
Employer: Work #:	Employer: Work #:
SSN: DOB:	SSN: DOB:
Family Email:	

Preferred Pharmacy:	**Address/Intersection:**
Primary Insurance:	**Secondary Insurance:**
Insured Name:	Insured Name:
Insurance Address:	Insurance Address:
City, State, Zip:	City, State, Zip:
Phone: Co-Pay $	Phone: Co-Pay $
Group # **ID #**	**Group #** **ID #**

I have read and agree to all insurance, consent, immunization treatment and payment policies unless otherwise noted.

_____ _____ _____

Signature (Parent/Guardian) Date Relationship to Patient

Emergency Contact:	Phone:	Relationship to Patient: