Date _____

PATIENT INFORMATION (Please Print)

Name _____ Date of Birth _____

Address _____ City _____ State_____ Zip _____

Phone ( )_____ Language _____

Race: **(circle one)**

American Indian or Alaskan Native
Asian
Black
Hawaiian Native or Pacific Islander
White
Declined to Answer

AND

Ethnicity: **(circle one)**

Unknown
Hispanic or Latino
Not Hispanic or Latino
Declined to Answer

PARENT INFORMATION

Mother _____Email Address _____SS#_____ DOB:_____
Address _____ City _____State _____ Zip _____
Phone ( )_____ Work ( )_____ Cell ( )_____
Occupation _____ Employer (company) _____

Father _____Email Address _____SS#_____DOB:_____
Address _____ City _____State _____ Zip _____
Phone ( )_____ Work ( )_____ Cell ( )_____
Occupation _____ Employer (company) _____

Emergency Contact if unable to reach you directly (Other than parents)
Name _____ Relation to Patient _____
Address _____ City _____State _____ Zip _____
Phone ( )_____ Work ( )_____ Cell ( )_____

Preferred phone contact number for: Medical information: _____

Reminders: _____

I consent to treatment of myself/my child for routine medical care, including physical exam, well child care, and vaccinations. (I understand that I have the right to refuse treatment.)

I hereby authorize Community Pediatrics, SC to release to my insurance carrier any information including the diagnosis and record of any treatment or examination. I also authorize and request that Community Pediatrics, SC be paid directly for services rendered. I understand and agree that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient/Guardian _____ Date _____
Reason for Guardian Signature _____

(For office use only)
Copy of Insurance Card _____ Immunization Record _____ Patient History _____ HIPPA _____
Medical Records _____ Requested From _____ Date Received _____
Advanced Directive ___ yes ___ no