PATIENT INFO: Last Name: First:

Street Address:

City, State, Zip:

Date of Birth: Age: Sex: Primary Language:

MOTHER/GUARDIAN INFO: Last Name: First Name:

Street address if same write "**SAME**":

City, State, Zip:

SS# Date of Birth: Marital Status:

Employer: Occupation:

Home Phone: Cell Phone: Work Phone:

Home Email: Work Email:

FATHER/GUARDIAN: Last Name: First Name:

Street Address if same write "**SAME**":

City, State, Zip:

SS#: Date of Birth: Marital Status:

Employer: Occupation:

Home Phone: Cell Phone: Work Phone:

Home Email: Work Email:

NOTIFICATION INFO:

What is the primary contact phone number for the patient with area code:_____

Best Method to contact you PLEASE CIRCLE: Text/Cell/Home/Work/Email

Ethnicity (Please circle ONE) Hispanic or Latino NOT Hispanic or Latino Decline to answer

Race (Please select all applicable) American Indian or Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander White/Caucasian Decline to answer

AUTHORITY TO OBTAIN MEDICAL TREATMENT:

Additional adults aged 18 or over who are authorized to obtain medical treatment for patient. (If none please write none DO NOT INCLUDE Parents and Guardians). Please note that payment is still due at the time of service if child is brought in by an authorized person.

Full Name of Adult:	Relationship to child:	Phone Number:

Pharmacy address or cross streets:

Pharmacy Phone number: