Great Kids Pediatrics

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Date: _____ Patient Information Sheet

Child's Name:_____ Date of Birth: _____
First Middle Last Month/Day/Year

Sex: Male/Female (Circle One)
Street Address: _____
City, State, Zip Code: _____
Telephone: (_____)_____
Email: _____

Patient Race: ___American Indian or Alaska Native/ ___Asian/ Native Hawaiian or Other Pacific Islander
___ Black or African American/ ___ White/ ___ Hispanic/ ___Other Race/ ___ Refuse to report

Patient Ethnicity: ___ Hispanic or Latino/ ___ Non-Hispanic/Latino/ ___ Refuse to report

Preferred Language: ___ English/ ___ Spanish/ ___ Other

Father's Name: _____ Mother's Name: _____
First Middle Initial Last First Middle Initial Last

Father's Date of Birth: _____	Mother's Date of Birth: _____
Social Security #: _____	Social Security #: _____
Driver's License #: _____	Driver's License #: _____
Occupation: _____	Occupation: _____
Employer Name: _____	Employer Name: _____
Work Phone: (___) _____	Work Phone: (___) _____
Cellular Phone: (___) _____	Cellular Phone: (___) _____
Insurance Name: _____	Insurance Name: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Insurance Phone: (___) _____	Insurance Phone: (___) _____

Person responsible for payment (if different than above) _____
Address and Telephone for Other Responsible Party: _____

Names & Dates of Birth of OTHER Children _____
Name of Previous Physician or clinic: _____
Person to notify in case of emergency (other than parents):
_____ Phone: (____)_____

Name of who referred you to our office or how you hear of us? _____

Pharmacy Name: _____ Phone: (____)_____