

**PATIENT INFORMATION**

Child's Full Legal Name (Last, First, Mid)	Date of Birth	Sex	Preferred Name
Child's Home Address (Street, City, State, Zip)	Telephone #	Parent's Email Address	
Other Children in Family (Name/DOB): 1. 2. 3. 4. 5.	Race: <input type="radio"/> African American/Black <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Caucasian/White <input type="radio"/> Native Hawaiian/Other Pacific Islander <input type="radio"/> Other _____	Ethnic Group: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic	
		Patient's Primary Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____	
		Parent's/ Legal Guardian's Primary Lang: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____	

**EMERGENCY CONTACTS**

Mother's Name	Phone #:	Alternate Phone #:
Mother's Home Address (if different from patient)		
Father's Name	Phone #:	Alternate Phone #:
Father's Home Address (if different from above)		
Additional Contact's Name	Relationship to Patient	Phone #
Additional Contact's Address		
Who may we thank for referring you to our practice?		

**GUARANTOR INFORMATION (Person financially responsible)**

Name	Date of Birth	Relationship to Patient
Street Address (if different from patient)		Phone Number
Employer Name/Address		Work Phone Number

**INSURANCE INFORMATION**

Insurance Name/Type	Claims Address	Telephone #
Subscriber/Member ID	Group #	Patient Relationship to Subscriber
Subscriber's Name		Subscriber's Date of Birth
Subscriber's Address (if different than guarantor)		Subscriber's Employer