

Patient's First Name	Patient's Last Name	DOB	Sex	<b>Child Lives With</b> <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian
1.				
2.				
3.				
4.				

<b>Father's Name:</b>		<b>Mother's Name:</b>	
<b>DOB:</b>	<b>SSN#:</b>	<b>DOB:</b>	<b>SSN#:</b>
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:	Cell:	Home Phone:	Cell:
Work #:		Work #:	
<b>Father's Email:</b>		<b>Mother's Email:</b>	

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
Subscriber's Name:	Subscriber's Name:
Co-Pay:	Co-Pay
Group # _____	Group # _____
ID # _____	ID # _____

<b>Preferred Pharmacy :</b>	<b>Pharmacy Address/Intersection:</b>
-----------------------------	---------------------------------------

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

\_\_\_\_\_  
**Signature (Parent/Guardian)**                      **Date:** \_\_\_\_\_                      **Relationship to Patient:** \_\_\_\_\_

<b>Emergency Contact:</b>	<b>Phone:</b>	<b>Relationship to Patient:</b>
---------------------------	---------------	---------------------------------

<b>Front Office Use Only:</b>	<b>Verified:</b>	<b>Scanned:</b>
<b>Medics:</b>		