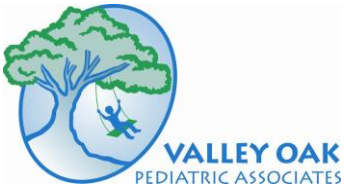

Patient Demographics

Child/Children's Primary Care Doctor: _____

Child's Name_____ DOB _____ Sex_____
Child's Name_____ DOB _____ Sex_____
Child's Name_____ DOB _____ Sex_____
Child's Name_____ DOB _____ Sex_____
Child's Name_____ DOB _____ Sex_____

IF DIVORCED/SEPARATED-CHILD/CHILDREN RESIDE WITH: _____

Preferred way to confirm appointments: □ Phone Call #_____□ Text #_____

Mother's primary contact number: □ Home □ Cell
Mother's Name _____ DOB _____
Home Phone #_____Cell Phone #_____ Work Phone #_____
Home Address _____ City _____ Zip Code _____
Mailing Address _____ City _____ Zip Code _____
SSN_____ Employer _____ E-mail address: _____
Stepfather's Name _____ DOB _____ Cell Phone #_____

Father's primary contact number: □ Home □ Cell
Father's Name _____DOB _____
Home Phone #_____ Cell Phone #_____ Work Phone #_____
Home Address _____ City_____ Zip Code_____
Mailing Address _____ City _____ Zip Code_____
SSN_____ Employer_____ E-mail address: _____
Stepmother's Name _____ DOB _____ Cell Phone#_____

Please initial acknowledgement of receipt of the following:
_____Handbook (A Patient Guide) includes the Code of Conduct.
_____Receipt of Privacy Practices (HIPAA)
_____Immunizations VIS Handouts (given prior to immunization being administered)

Date_____

Print Name_____ Signature _____
(Parent/Legal Guardian) (Parent/Legal Guardian)