

PRIMARY PARENT / GUARDIAN

PARENT / GUARDIAN NAME		DATE OF BIRTH (MM/DD/YYYY)	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>
RELATIONSHIP TO PATIENT	LIVES WITH PATIENT	SSN	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
PRIMARY ADDRESS			
<input type="text"/>			
CITY	STATE	ZIP	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
PRIMARY PHONE	WORK PHONE	CELL PHONE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
EMPLOYER	OCCUPATION		
<input type="text"/>	<input type="text"/>		
PERSONAL EMAIL	PHARMACY NAME		
<input type="text"/>	<input type="text"/>		
PHARMACY PHONE	PHARMACY FAX		
<input type="text"/>	<input type="text"/>		

Preferred contact method for:

MEDICAL ISSUES	REMINDERS	RECALLS
<input type="text"/>	<input type="text"/>	<input type="text"/>
BILLING STATEMENTS	GENERAL NOTICES	PATIENT PORTAL
<input type="text"/>	<input type="text"/>	<input type="text"/>

SECONDARY PARENT / GUARDIAN (OPTIONAL)

PARENT / GUARDIAN NAME		DATE OF BIRTH (MM/DD/YYYY)	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>
RELATIONSHIP TO PATIENT	LIVES WITH PATIENT	SSN	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
PRIMARY ADDRESS			
<input type="text"/>			
CITY	STATE	ZIP	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
PRIMARY PHONE	WORK PHONE	CELL PHONE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
EMPLOYER	OCCUPATION		
<input type="text"/>	<input type="text"/>		
PERSONAL EMAIL	PHARMACY NAME		
<input type="text"/>	<input type="text"/>		
PHARMACY PHONE	PHARMACY FAX		
<input type="text"/>	<input type="text"/>		

Preferred contact method for:

MEDICAL ISSUES	REMINDERS	RECALLS
<input type="text"/>	<input type="text"/>	<input type="text"/>
BILLING STATEMENTS	GENERAL NOTICES	PATIENT PORTAL
<input type="text"/>	<input type="text"/>	<input type="text"/>

CHILD 1

PATIENT / CHILD NAME DATE OF BIRTH (MM/DD/YYYY) SEX

PRIMARY ADDRESS CITY STATE ZIP

EMERGENCY CONTACT PRIMARY PHONE PERSONAL EMAIL

LANGUAGE ETHNICITY RACE

CHILD 2

PATIENT / CHILD NAME DATE OF BIRTH (MM/DD/YYYY) SEX

PRIMARY ADDRESS CITY STATE ZIP

EMERGENCY CONTACT PRIMARY PHONE PERSONAL EMAIL

LANGUAGE ETHNICITY RACE

CHILD 3

PATIENT / CHILD NAME DATE OF BIRTH (MM/DD/YYYY) SEX

PRIMARY ADDRESS CITY STATE ZIP

EMERGENCY CONTACT PRIMARY PHONE PERSONAL EMAIL

LANGUAGE ETHNICITY RACE

CHILD 4

PATIENT / CHILD NAME DATE OF BIRTH (MM/DD/YYYY) SEX

PRIMARY ADDRESS CITY STATE ZIP

EMERGENCY CONTACT PRIMARY PHONE PERSONAL EMAIL

LANGUAGE ETHNICITY RACE

PRIMARY INSURANCE

SUBSCRIBER'S NAME	DATE OF BIRTH (MM/DD/YYYY)	SEX
<input type="text"/>	<input type="text"/>	<input type="text"/>
SUBSCRIBER ID #	PATIENT RELATIONSHIP TO SUBSCRIBER	
<input type="text"/>	<input type="text"/>	
INSURANCE CARRIER	GROUP #	GROUP NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>

AUTHORIZED PERSONS (OTHER THAN PARENT / GUARDIAN)

Persons authorized to accompany the child to appointments. Photo ID required at each visit.

NAME	RELATIONSHIP
<input type="text"/>	<input type="text"/>
NAME	RELATIONSHIP
<input type="text"/>	<input type="text"/>

ACKNOWLEDGEMENT

I certify that the information provided above is accurate and complete to the best of my knowledge, and I authorize Vero Beach Pediatrics to use it for treatment, payment, and healthcare operations.

SIGNATURE OF PARENT / GUARDIAN	DATE (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>