

STEP BY STEP PEDIATRICS DEMOGRAPHICS

PLEASE PRINT ALL INFORMATION

Doctor (circle)

Dr. McClellan

Dr. Niland

Dr. Tansky

Dr. Miller

CHILDREN (Please list all children and their dates of birth)

Table with columns: Child's Name, Date of Birth, Child's Name, Date of Birth. Includes gender selection (M/F) for each child.

ADDRESS: NUMBER, STREET, APT#, CITY, STATE, ZIP

PRIMARY TELEPHONE NUMBER ( )

MAY WE LEAVE A MESSAGE? Y/N

PRIMARY EMAIL ADDRESS

PARENT INFORMATION:

MOTHER: LAST, FIRST, MIDDLE, SSN

ADDRESS: NUMBER, STREET, APT#, CITY, STATE, ZIP

PHONE ( ) HOME, ( ) WORK, ( ) CELL

DOB

FATHER: LAST, FIRST, MIDDLE, SSN

ADDRESS: NUMBER, STREET, APT#, CITY, STATE, ZIP

PHONE ( ) HOME, ( ) WORK, ( ) CELL

DOB

EMERGENCY CONTACT (someone other than the parent/lives outside the home)

NAME, PHONE, RELATIONSHIP

SUBSCRIBER TO PATIENTS INSURANCE: NAME, RELATIONSHIP, DOB

FINANCIALLY RESPONSIBLE PARTY: NAME, RELATIONSHIP, DOB