DAWSON PEDIATRICS

****We will need a copy of Driver's License and Insurance Card at each visit.****

Patient Information Form

Child's Name ________________________ DOB ____/____/____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American …. Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Child's Name ________________________ DOB ____/____/____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American …. Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Child's Name ________________________ DOB ____/____/____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American …. Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Child's Name ________________________ DOB ____/____/____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American …. Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Preferred Language *(circle one)*: ENGLISH SPANISH OTHER_________ Preferred Method of Contact___________

Child(ren) reside(s) with: ☐ Mother ☐ Father ☐ Guardian Other: ______________________
*** If child is in custody of someone other than parent(s), we **HAVE** to have current copies of custody forms or guardianship paperwork on file. ***

Mother's name________________________ DOB ____/____/____ SS# _____ - _____ - _____
Street address ________________________ *City* ______________ *State* _____ *Zip* ________
Home phone ________________ *Cell* ________________ *Work* ________________
Employer ________________________ *E-mail:* ________________________

Father's name________________________ DOB ____/____/____ SS# _____ - _____ - _____
Street address ________________________ *City* ______________ *State* _____ *Zip* ________
Home phone ________________ *Cell* ________________ *Work* ________________
Employer ________________________ *E-mail:*________________________

Guardian's name________________________ DOB ____/____/____ SS#_____ - _____ - _____
Relationship to patient________________________ *Start Date of Guardianship*________________________
Street address ________________________ *City*______________ *State*_____ *Zip* ________
Home phone ________________ *Cell* ________________ *Work* ________________
Employer ________________________ *E-mail:*________________________

Emergency Contact *(other than parent/guardian):*________________________ Ph #________________
Relationship________________________

Preferred Pharmacy________________________ City________________ Ph #________________

Insurance Co ________________________ ID # ________________________ Group # ________________
Policyholder's Name ________________________ DOB ______________ Relationship☐Patient ______________
Does this patient have Secondary Insurance? __Yes __No *(If yes, please notify the receptionist)* NO INSURANCE *(Self-pay)*

*** Who can we thank for referring you to our office? ___ Friend ___ Insurance ___ Website Other________________

Parent/Guardian Signature: ________________________________ **Date:** ____________

Revised: 12/2016