



Patient Information

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|---------------|---|--|
| Patient Name: | Date of Birth: Social Security Number: | Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Child's Race: | Child's Ethnicity: | Patient Adopted or In Custody: <input type="checkbox"/> Yes (if yes, please provide legal documentation for patient's chart) <input type="checkbox"/> No |

Parent/Legal Guardian Information

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|--------------------------|--------------------------|
| Parent/Legal Guardian 1: | Parent/Legal Guardian 2: |
| Date of Birth: | Date of Birth: |
| Social Security Number: | Social Security Number: |
| Address: | Address: |
| Primary Phone Number: | Primary Phone Number: |
| Secondary Phone Number: | Secondary Phone Number: |
| Email Address: | Email Address: |

Private Primary Insurance

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|---------------------|----------------|---------|
| Plan Name: | Policy ID#: | Group#: |
| Policy Holder Name: | Date of Birth: | SS#: |

Private Secondary Insurance

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|---------------------|----------------|---------|
| Plan Name: | Policy ID#: | Group#: |
| Policy Holder Name: | Date of Birth: | SS#: |

Parent or legal Guardian Signature:

Date.