☼ **Welcome** ☼

DAVENPORT PEDIATRICS

PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ NICKNAME: _____
Last Name First Name MI

ETHNICITY/ RACE: _____ PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other_____

SOCIAL SECURITY #: _____-_____-_____ SCHOOL: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ EMAIL ADDRESS: _____

HOME ADDRESS: _____ DATE OF BIRTH: ____/____/_____ AGE: _____
MM DD YYYY

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____ SEX: M / F

MAILING ADDRESS IF DIFFERENT: _____

HOW DID YOU HEAR ABOUT OUR SERVICES: ☐ PHYSICIAN ☐ HOSPITAL ☐ RELATIVE ☐ ADVERTISEMENT ☐ OTHER_____

PARENT OR GUARDIAN INFORMATION

NAME OF RESPONSIBLE PARTY/
PARENT OR GUARDIAN ACCOMPANYING CHILD: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____	SOCIAL SECURITY#: _____-_____-_____ RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/_____/_____ SEX: M F MM DD YYYY
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ EMAIL: _____	OCCUPATION: _____ EMPLOYER: _____ EMPLOYMENT STATUS: _____ BEST WAY TO CONTACT: _____
PATIENT LIVES WITH: _____	RELATIONSHIP TO PATIENT: _____

NAME OF OTHER PARENT/ GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____	SOCIAL SECURITY#: _____-_____-_____ RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/_____/_____ SEX: M F MM DD YYYY
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ EMAIL: _____	OCCUPATION: _____ EMPLOYER: _____ EMPLOYMENT STATUS: _____ BEST WAY TO CONTACT: _____

EMERGENCY CONTACT INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PERSONS LISTED ABOVE)

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____ OTHER: _____

PREFERRED PHARMACY NAME/ LOCATION: _____ PHONE: (_____) _____-_____

CONSENT FOR TREATMENT

I certify that the information I have provided above is current and correct.

I hereby authorize DAVENPORT PEDIATRICS, P.A., its physicians and support staff to provide medical care to the patient named above. I voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician(s) in charge. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any examination or treatment received from DAVENPORT PEDIATRICS, P.A.

This consent is valid for the entire duration of my association with DAVENPORT PEDIATRICS, P.A. and may be relied upon by DAVENPORT PEDIATRICS, P.A. unless and until such consent is revoked in writing.

PRINTED NAME OF PARENT/ GUARDIAN: _____

SIGNATURE OF PARENT/ GUARDIAN: _____ **DATE:** _____
MM / DD / YYYY