# PATIENT INFORMATION FORM

Account #: _____

Please list all children in the family.

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Home Address: _____
Street City State Zip

**PRIMARY: (_____)_____-_____** Secondary: (_____)_____-_____ Email: _____

EMERGENCY CONTACT: _____ Phone: (_____)_____-_____
Name

**I authorize Beach Pediatrics to leave messages or send text messages at the primary number listed above regarding my child's health, appointments, test results, and billing unless otherwise specified. ☐ Yes ☐ No**

Please select all that apply *(optional)*: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ Asian

Please circle one. **Mother / Father / Guardian**

Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Address: _____ Home:(____)_____-_____
(if different from patient's) _____ Cell: (____)_____-_____

Occupation: _____

Employer: _____

Please circle one. **Mother / Father / Guardian**

Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Address: _____ Home:(____)_____-_____
(if different from patient's) _____ Cell: (____)_____-_____

Occupation: _____

Employer: _____

Parents of the child/children are: ☐ Single ☐ Married ☐ Divorced ☐ Separated

If the parents are divorced or separated, what are the legal custody arrangements for the child/children? ☐ Sole ☐ Joint

**If sole legal custody, please provide legal documentation to be scanned into patient(s)'s chart.**

**CAREGIVER AUTHORIZATION** — I, the parent/guardian, give authorization to the following relatives and/or caregivers to bring my child/children in for sick visits, testing and/or treatment which is recommended and provided by the physicians and staff of Beach Pediatrics. **This Authorization will remain in effect until further written notice.**

Name/Relationship:_____ Name/Relationship:_____

**PRIMARY INSURANCE INFORMATION**

Insurance Name: _____

Name of Subscriber: _____

ID#: _____

Group #:_____

**SECONDARY INSURANCE INFORMATION**

Insurance Name: _____

Name of Subscriber: _____

ID#: _____

Group #:_____

**PHARMACY**

Name: _____ Location/Zip:_____ Phone: (_____) _____-_____

**I declare the information I provided above is correct, and if there are any changes, I will notify Beach Pediatrics.**

Parent/Guardian Signature: _____ Date: _____/_____/_____