FAMILY INFORMATION **DATE COMPLETED: _____**

Thank you for choosing our office. In order to serve you properly, we need the following information. Please PRINT and fill out this form completely.

Parent's Name: _____ Parent's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____

Primary E-mail Address: _____

Referred by: _____

Preferred method for appointment reminder (please enter number or email):
TEXT:_____ EMAIL:_____PHONE:_____

CHILDREN:

1._____ DOB: _____ M / F

2._____ DOB: _____ M / F

3._____ DOB: _____ M / F

4._____ DOB: _____ M / F

5._____ DOB:_____ M / F

6._____ DOB:_____ M / F

PARENT: DOB: _____

First and Last Name : _____

Occupation: _____

Employed by: _____

Work Number_____ Cell Number _____

PARENT: DOB_____

First and Last Name: _____

Occupation: _____

Employed by: _____

Work Number_____ Cell Number _____

OTHER PHONE NUMBERS:

Day Care Name: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

INSURANCE INFORMATION:

Primary Insurance Policy Holder's Name: _____

Insurance Company: _____

ID Number: _____

Union or Local Number: _____ Group Number: _____

Deductible Amount: _____ Co-Pay Amount: _____

Secondary Insurance Policy Holder's Name: _____

Insurance Company: _____

ID Number: _____

Union or Local Number: _____ Group Number: _____

Deductible Amount:_____Co-Pay Amount: _____

ELIGIBILITY WAIVER:

Parents are expected to attend all wellness visits until patients reach the age of 18.

During the first 3 years of life, we see infants for routine well childcare at:
1 month of age, **2 months** of age, **3 months** of age, **4 months** of age, **5 months** of age, **6 months** of age, **7 months** of age, **9 months** of age, **12 months** of age, **15 months** of age, **18 months** of age, **2 Years** of age, **2 ½ years** of age, **3 years** of age, and **annually** thereafter.

Please verify that your insurance company provides full coverage for these visits prior to the visit.

If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature
(Parent or Legal
Guardian)_____Date:_____