ABC PEDIATRICS, LTD

☐Gus Rousonelos, MD	☐Erin Shanks, MD	☐Karolyn Law, MD	☐Ushma Patel, MD	☐Pamela Persak, MD

PATIENT INFORMATION

Last Name	First Name	Middle Name	Date of Birth	Sex
				☐Male ☐Female
				☐Male ☐Female
				☐Male ☐Female
				☐Male ☐Female
				☐Male ☐Female

PATIENT ADDRESS

Address:

City, State, Zip:

Mail Statements to this address? ☐Yes ☐No

PRIMARY PHONE:

PRIMARY EMAIL:

PARENT INFORMATION

MOTHER/GUARDIAN 1		**FATHER/GUARDIAN 2**	
Last Name:		Last Name:	
First Name:	DOB:	First Name:	DOB:
IF DIFFERENT THAN ABOVE		**IF DIFFERENT THAN ABOVE**	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Mail Statements to this address? ☐Yes ☐No		Mail Statements to this address? ☐Yes ☐No	
Cell Phone:		Cell Phone:	
Email Address:		Email Address:	
Employer:		Employer:	
Work Phone:		Work Phone:	
Are you the primary insurance carrier? ☐Yes ☐No		Are you the primary insurance carrier? ☐Yes ☐No	

PREFERRED CONTACT METHOD

☐Primary Phone ☐Primary Email ☐Cell Phone ☐Work Phone

PREFERRED PHARMACY

Name:	Phone:
Address:	City, State, Zip:

LOCAL CONTACT *(OTHER THAN PARENT)*

Last Name:	First Name:
Home Phone:	Cell Phone:
Email:	Relationship to patient:

AUTHORIZATION AND ACKNOWLEDGEMENT

I authorize you to give my child/children reasonable and proper medical care by today's standards. I hereby authorize the physician to release information related to any claim. I recognize and accept full responsibility for all professional services rendered and further authorize the insurance company to pay benefits directly to the physician.

Signature of Parent: _____ **Date:** _____

How were your referred to our practice? _____