PRIMARY PHYSICIAN: Dr. Spewak ____ Dr. O'Neil ____ Dr. Whiteside ____ Dr. AuBuchon ____ Dr. Menolascino ____

Who referred you to our office? _____ Number of Children with our office: _____

PATIENT INFORMATION: *(Please list each child's full name)* Today's Date:_____

1. _____ Date of birth _____ Sex M F
2. _____ Date of birth _____ Sex M F
3. _____ Date of birth _____ Sex M F
4. _____ Date of birth _____ Sex M F

Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip: _____

❑ Mother ❑ Father ❑ Guardian

Name: _____

Birth Date: _____

Place of employment: _____

Cell #: _____ Wk.#: _____

❑ Mother ❑ Father ❑ Guardian

Name: _____

Birth Date: _____

Place of employment: _____

Cell #:_____ Wk. #:_____

Marital Status of Parents: Single Married Divorced Separated

E-mail Address: _____

In the case of an emergency please provide the name and number of someone not living at your address:

Name: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone ( ) _____

CONSENT: I give my consent for the following person(s) to bring my child(ren) for medical treatment.

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

INSURANCE INFORMATION:

Parent or guardian responsible for child(ren): _____

NOTE: The majority of insurance carriers use "birthday rule" (whichever parent's birthday is firstinthe Calendar year) to decide primary coverage for the child.

Primary Insurance Co.

Insurance Co.: _____

Insured Parent: _____

ID Number: _____/Group #:_____

EffectiveDate:_____

Secondary Insurance Co.

Insurance Co.: _____

Insured Parent: _____

ID Number: _____/Group #:_____

E ffectiveDate:_____

If Insured Parent different than Mother/Father's names listed at top, please provide:

Insured Parent's Name: _____

Date of Birth: _____

Relationship to Patient: _____

Place of Employment: _____

Phone #: _____ Home: _____

Work: _____

Signed: _____ ***Date*** _____

Parent/Legal Guardian