Date________________ How did you hear about Med 4 Kids? ________________

Patient's Name____ Male Female

Date of Birth______________

Names & DOB Siblings ____

____

Home Address____

City____ State______ Zip ________________

Home Phone ________________ Cell Phone_____________ Emergency ______________

Allergies_____________________ Current Medication______________________________

Mother's Name_____________________________________ SS# ____________________

Address (if different from above)____

Date of Birth ___________________________

Employer _______________________________________ Work Phone________________

Father's Name_____________________________________ SS# ____________________

Address (if different from above)____

Date of Birth ___________________________

Employer_______________________________________ Work Phone ________________

Primary Insurance ____

Policy or Identification Number____

Subscriber's Name___________________________________ Relationship ____________

Other Insurance ____

Email Address____

I authorize Med 4 Kids to release any medical or incidental information that may be necessary for either medical care or in the processing of insurance; and I direct payment of medical benefits to Med 4 Kids for services rendered. I understand that I am financially responsible for any balance not covered by insurance.

Signature of Parent or Legal Guardian____