Welcome to Pediatrics West

Thank you for choosing our practice. All information will be STRICTLY CONFIDENTIAL

Today's Date ________________

Patient's Name ____ Date of Birth _____________
(Last) (First) (MI)

Street Address ____ Sex: M F

City _____________________________ State ____________ ZIP _________________

Main Phone # ______________________________ Patient's Cell # (if over 13) ______________________

E-mail Address ____

Parent/Guardian 1 ______________________________ Parent/Guardian 2 ___________________________________

Address_______________________________________ Address ____

_______________________________________ ____

Phone # ______________________________________ Phone # ____

Relationship to Patient _________________________ Relationship to Patient _______________________________

Date of Birth _______________________________ Date of Birth ______________________________

Siblings: Name __________________________ Date of Birth ______________________________

Name __________________________ Date of Birth ______________________________

Subscriber Information (person who carries insurance)

Name ____

Street Address ____

City ______________________________ State _____________ ZIP _____________________

Phone # _____________________________ Social Security Number _______________________________

Emergency Contact (other than parent/guardian) ____

Relationship to Patient ___________________________________ Phone # ________________________

Optional

Race (circle) *Asian* *Black/African American* *Caucasian* *Chinese* *Hispanic* *Japanese*

American Indian or Alaskan Native *Latino* *Multiracial* *Pacific Islander* *Other* ___________________

Ethnicity (circle) *Hispanic* *Non-Hispanic* *White* *Other* ____________________________

Language (circle) *English* *French* *German* *Hindi* *Mandarin* *Spanish* *Vietnamese* *Other* _________________