



Last Name _____ First Name _____ MI _____
DOB _____ Gender M / F

Parent/Guardian #1 _____

Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Address _____ City _____ State _____ Zip _____

Parent/Guardian #2 _____

Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Address _____ City _____ State _____ Zip _____

If parents do not live together:
Who is responsible for healthcare costs? _____
Who does the child live with most of the time? _____
Are there any custody issues that we need to be aware of? _____
Please list the name and phone number of any parents or stepparents not listed above _____

Who carries the insurance for this child? _____ DOB _____
Address (If different from above) _____ City _____ State _____ Zip _____

Do you have any concerns about transportation, food, or housing? _____

What is your preferred method of contact? _____ Text _____ Call _____ email _____

Preferred Pharmacy Name: _____ City _____

Please initial the following items:

- _____ I hereby consent that all information listed above is up to date and accurate.
- _____ I hereby consent to medical treatment in our office today, including laboratory tests, immunizations, procedures, and physical exam.
- _____ I hereby consent that the practice may disclose Health Information so that others may bill and receive payment from me, an insurance company, or a third party for the treatment and services received.
- _____ I hereby consent that the practice can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.
- _____ I hereby consent that medical providers at Redwood Pediatrics may discuss pertinent health information with outside medical providers as deemed necessary by those providers to provide medical care.

Signature of Parent or Guardian _____ Date _____

Relationship _____