FAMILY INFORMATION SHEET

Family Last Name: ________________________ **Doctor:**____________________________

Child's Address ____
Street City Zip

Father: ____________________________ Soc. Sec. _____________ DOB: ______________

Home Phone Number:__________________Cell Phone Number: _______________________

Work Phone Number: ____

Father's Address: ____
Street City Zip

Employer: ___________________________Occupation:_______________________________

Mother: ___________________________ Soc. Sec. _____________ DOB: ______________

Home Phone Number:__________________Cell Phone Number: _______________________

Work Phone Number ____

Mother's Address:____

Employer: ___________________________Occupation:_______________________________

Emergency Contact (other than parents): _____________Phone: _______________________

Primary Insurance Company: _____________________ Name of Insured: ________________

Policy Number: ____________________________________ Co-Pay:______________________

Parent Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐ Separated ☐Partners

Family History: ☐Tuberculosis ☐Diabetes ☐Asthma ☐Cancer
☐Mental Illness ☐Birth Defects ☐Drug Allergies ☐Seizures
☐Inherited Diseases ☐Heart Disease ☐Hypertension ☐Other
☐Allergies (list)____

Children: First Name	Last Name	Date of Birth	Health Problems Drug Allergies

I authorize payment of medical benefits to the above named physician. I also agree to the release of any pertinent medical information necessary to expedite insurance payment.

Signed: ____**Date:** ______________________