New Patient Form-Child (Under 18)

Full Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Gender (circle one): Male Female

Email: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Who referred you to our office? _____

Ethnicity* (circle one): Hispanic/Latino Non-Hispanic/Latino I decline to answer

Race* (circle one): American Indian or Alaska Native / Asian / Black or African American /
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to answer

Does child live with (circle one): Both Parents Father Mother

Mother's Name: _____ Work/Cell Phone: _____

Occupation: _____ Employer: _____

Father's Name: _____ Work/Cell Phone: _____

Occupation: _____ Employer: _____

Please circle the type of care you desire: Temporary relief / Long-term corrective / Dr. Recommendation

Preferred method of communication for patient reminders: Email / Phone / Mail

*Required per Federal Guidelines