DURANT ROAD PEDIATRICS

Demographics

Today's Date:_____

Child's Full Name:_____ **DOB:**_____
Nickname:_____
Male ( ) **Female ( )** **Race:**_____
Social Security #:_____ **Ethnicity:**_____

Referring family (if applicable):_____

Primary Tel #:_____ **e-mail:**_____

Mom's Name:_____ **DOB:**_____
Cell #:
Work #:_____ **Employer:**_____
Address:_____

Dad's Name:_____ **DOB:**_____
Cell #:_____
Work #:_____ **Employer:**_____
Address (If Different):_____

Siblings

Name:_____ **DOB:**_____
Name:_____ **DOB:**_____
Name:_____ **DOB:**_____

Insurance Information

Primary Insurance Company:_____
Subscriber's Name:_____ **DOB:**_____
Relationship to Patient:_____
Place of Employment:_____
Social Security #:_____
Insurance Policy #:_____
Group #:_____

Secondary Insurance Company:_____
Subscriber's Name:_____ **DOB:**
Relationship to Patient:_____
Place of Employment:_____
Social Security #:_____
Insurance Policy #:_____

(THIS FORM IS DOUBLE-SIDED, SEE THE OTHER SIDE)

Group #:_____

Emergency Contacts

Name:_____ **Relationship:**_____
Phone #:_____

Name:_____ **Relationship:**_____
Phone #:_____

Name:_____ **Relationship:**_____
Phone #:_____

Pharmacy Information

Pharmacy Name:_____ **Phone #:**_____
Location:_____

Consent to Treat and Vaccinate

I authorize Durant Road Pediatrics to treat my child including administration of routine childhood vaccinations per the AAP Vaccination schedule. A copy of the CDC VIS (Vaccine Information Sheet) will be provided to me for review at the time of vaccination and I will have the opportunity to ask any questions regarding the risks and benefits of the vaccine at that time.

_____ _____
Signature (Parent/Guardian/Child over 18 years of age) **Date**

_____
Name Printed