Canterbury Pediatrics

First: _____ Middle:_____ Last: _____

Date of Birth: _____ Sex: Male / Female

Nickname/Preferred Name: _____

Race: (Circle One)
American Indian/Alaska Native
Asian
Black / African American
Declined
Native Hawaiian / Pacific Islander
Other Race
White / Caucasian

Ethnicity: (Circle One)
Declined
Hispanic or Latino
Not Hispanic or Latino

Demographic Information

Street Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

Please circle which phone number is primary Email Address: _____

Preferred Pharmacy (please specify town and street): _____

Parents / Legal Guardian

*Mother / Legal Guardian: _____ Date of Birth: _____

Lives with Child: Yes / No

*Father / Legal Guardian: _____ Date of Birth: _____

Lives with Child: Yes / No

Insurance Information – A copy of your insurance card is required (front and back) *

Financially Responsible Person (please specify if address is different than above): _____

_____

Primary Insurance Plan: _____ Policy #: _____

Secondary Insurance Plan: _____ Policy #: _____

Who else has permission to bring this child to Canterbury Pediatrics and authorize treatment?

Name: _____ Relationship to Patient: _____ Phone #: _____

Name: _____ Relationship to Patient: _____ Phone #: _____

*Authorization to Release Medical Information for Insurance Purpose Only?

Signature Required: _____ Name/Relationship: _____

** All information is confidential and will not be released without the written permission of parent or legal guardian as protected by H.I.P.P.A.