



121 JPM ROAD
LEWISBURG, PA 17837
TEL: 570-551-0300

Patient and Family Information

Child 1: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: African American American Indian or Native Alaskan Asian
 Hawaiian or Pacific Islander White Other Decline:

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown Decline

Child 2: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: African American American Indian or Native Alaskan Asian
 Hawaiian or Pacific Islander White Other Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown Decline

Child 3: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: African American American Indian or Native Alaskan Asian
 Hawaiian or Pacific Islander White Other Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown Decline

Child 4: Last Name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Sex: M / F Preferred Language: _____

Race: African American American Indian or Native Alaskan Asian
 Hawaiian or Pacific Islander White Other Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unknown Decline

Pharmacy Name: _____ Pharmacy Phone #: _____

Parent/Legal Guardian #1:

Child(ren)'s parents are: Married Divorced Never Married Separated Widow(er) Other

Name: _____ Relationship to Patient: _____

DOB: ____/____/____ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____

Best number to reach me is: Home Cell Work

Ideal Pediatric & Adolescent Care may contact me via: Home Cell Work Email

Ideal Pediatric & Adolescent Care may leave messages or lab results via:

Home Cell Work Email

Lives with patient? Yes / No

(Street) (City/State/Zip)

Parent/Legal Guardian #2:

Name: _____ Relationship to Patient: _____

DOB: ____/____/____ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____

Best number to reach me is: Home Cell Work

Ideal Pediatric & Adolescent Care may contact me via: Home Cell Work Email

Ideal Pediatric & Adolescent Care may leave messages or lab results via:

Home Cell Work Email

Lives with patient? Yes / No

If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1):

(Street) (City/State/Zip)

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? Yes / No

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Emergency Contacts, other than parents. Name & Relationship:

Name: _____ Phone: _____

Name: _____ Phone: _____