EXETER PEDIATRICS

PLEASE PRINT TODAY'S DATE _____ SEX F M

CHILD'S NAME _____ BIRTH DATE _____

ADDRESS_____

CELL PHONE IF 18 YRS_____SOCIAL SECURITY NUMER_____

MOTHER'S MAIDEN AND MARRIED NAME_____BIRTHDATE_____

ADDRESS_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

EMAIL ADDRESS_____SOCIAL SECURITY NUMBER_____

FATHER'S NAME_____ BIRTH DATE_____

ADDRESS_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

EMAIL ADDRESS_____SOCIAL SECURITY NUMBER_____

CIRCLE ONE. WHICH PARENT SHOULD WE CONTACT FIRST? M OR F WHICH NUMBER SHOULD WE CALL FIRST (H) (W) (C)

IF WE CAN NOT REACH A PARENT, PLEASE GIVE THE NAME OF ANOTHER PERSON FOR EMERGENCY PURPOSES.

EMERGENCY CONTACT NAME_____

RELATIONSHIP TO CHILD_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

OTHER CHILDREN IN FAMILY

NAME NICKNAME BIRTHDAY

_____

_____

_____

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I CONSENT TO EXAMINATION, TREATMENT, AND PROCEDURES WHICH MAY BE PERFORMED DURING OFFICE VISITS, INCLUDING EMERGENCY TREATMENT, CONSIDERED NECESSARY BY THE PHYSICIAN. I AUTHORIZE EXETER PEDIATRICS TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF EXAMINATION OR TREATMENT FOR INSURANCE. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF REASONABLE ATTORNEYS FEES AND COLLECTION EXPENSES, IF REQUIRED, FOR THE COLLECTION OF THIS AGREEMENT.

SIGNED_____ DATE_____