

PALM BEACH PEDIATRICS, PA

Patient's Last Name _____ First _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Patient's social security # _____

Sex (circle one) Male Female
 Race (circle one) 1-Hispanic or Latino or Spanish origin 2-Non Hispanic or Latino or Spanish origin 3-Refuse
 Ethnicity (circle one) 1-American Indian or Alaska Native 2-Asian 3-Black or African American 4-White
 5-Native Hawaiian or Other Pacific Islander 6-Refuse

Home phone _____ Cell phone (mom) _____ Cell phone (dad) _____

E-mail address _____

List siblings first & last name and DOB _____

Who referred you to Palm Beach Pediatrics? _____

Circle the primary office you will attend: Royal Palm Haverhill Boynton Beach

Information on both parents must be filled out completely

Father	Mother
Name:	Name:
Address:	Address:
Employer:	Employer:
Address:	Address:
Work phone:	Work phone:
Occupation:	Occupation:
Social security #	Social security #
Driver's license #	Driver's license #

Name of primary insurance holder _____ DOB: _____

Insurance company name _____

ID # or Member # _____

Group # _____

Pharmacy _____

Emergency contact person _____ Phone # _____

Person(s) authorized to bring child in for appointments _____

(Must be 18 years or older)

Password to be used for authorization _____

Signature of Parent or Legal Guardian

Date

Print name of parent or legal guardian completing form

We are available to see your child 365 days a year, if it is necessary.

We have late night hours most nights of the week and are available to see sick children on the weekends.