Suburban Pediatrics, Inc.

Date _____

Patient Information

Patient Name _____ Male/Female Birthdate ___/___/___

Race: ☐ American Indian/Alaska Native ☐Asian ☐ Black/ African American
☐ Hawiian or Pacific Islander ☐White

Ethnicity: ☐ Hispanic or Latino ☐Non-Hispanic

Siblings Names _____

Home Phone (_____) _____ Social Security # (if available) _____

Address _____ City _____ State ____ Zip _____

Preferred Pharmacy Name, Phone and/or Address _____

Responsible Party Information

Parent Name (or Guardian) _____ Phone (_____) _____

Address _____ City _____ State ____ Zip _____

Employer _____Work Phone (_____) _____

Birthdate ___/___/___ SSN _____ Cell Phone (_____) _____

Parent Name (or Guardian) _____ Phone (_____) _____

Address _____ City _____ State ____ Zip _____

Employer _____Work Phone (_____) _____

Birthdate ___/___/___ SSN _____ Cell Phone (_____) _____

Emergency Contact _____ Phone (_____)_____
Referred by _____

Insurance Information

Primary Insurance _____ ID#_____ Group/Plan # _____

Subscriber's Name _____ Birthdate ___/___/___

Secondary Insurance _____ ID# _____ Group/Plan # _____

Subscriber's Name _____ Birthdate ___/___/___

As the parent of _____ I give Suburban Pediatrics, Inc. permission to treat and/or immunize my child in the event that I am unable to accompany him or her to the office. I understand that in all situations the doctors prefer to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving advance consent to any medical procedure the physician deems necessary.

Signature _____ Date _____