PATIENT INFORMATION PLEASE LIST **ALL** CHILDREN WE WILL BE CARING FOR

PATIENT(S) NAME	DATE OF BIRTH

ADDRESS INFORMATION

Fathers name:	Mothers name:
Address:	Address:
City:	City:
State: Zip:	State: Zip:
Home phone:	Home phone:
Cell phone:	Cell phone:
Work phone:	Work phone:

*****PLEASE INDICATE WHICH PHONE NUMBER IS THE PREFERRED CONTACT*****

PHARMACY INFORMATION

THIS INFORMATION WILL BE KEPT ON FILE. IF MEDICATION IS PRESCRIBED FOR YOUR CHILD IT WILL BE E-SCRIBED TO YOUR PHARMACY FOR FASTER SERVICE (UNLESS OTHERWISE INDICATED)

PHARMACY PHONE #:
NAME OF PHARMACY:
LOCATION (CROSS STREETS) ZIP CODE:

ARE THERE ANY KNOW DRUG ALLERGIES? _____

_____

EMAIL INFORMATION

EMAIL INFORMATION WILL BE ADDED TO OUR PRIVATE EMAIL ACCOUNT FOR OFFICE UPDATES/IMMUNIZATION/SCHEDULING REMINDERS ONLY

PRIMARY EMAIL ADDRESS:
ALTERNATE EMAIL ADDRESS (OPTIONAL):

	PLEASE CHECK THE BOX IF YOU WOULD LIKE TO SIGN UP FOR OUR PATIENT PORTAL. A LINK WILL BE EMAILED TO YOU TO CREATE A LOG IN AND PASSWORD.
THE PATIENT PORTAL WILL GIVE YOU ACCESS TO IMMUNIZATION RECORDS, SHOW ANY APPOINTMENTS SCHEDULED-REQUEST TO SCHEDULE APPOINTMENTS, VIEW BALANCES, UPDATE YOUR CHILDS RECORDS.	