Hartman
PEDIATRICS

Patient and Family Information

Child's Legal Name	Preferred First Name	DOB	Sex (circle one)
			M / F
			M / F
			M / F
			M / F

Address: _____City:_____Zip:_____

E-mail address: _____

Pharmacy Name/location:_____

Parent/Legal Guardian #1:

Name: _____DOB:___/_____/_____Phone:_____

Work Phone: _____Employer: _____

Lives with patient full time? (circle one) Yes / No If no, provide full address:_____

Parent/Legal Guardian #2:

Name: _____DOB:___/_____/_____Phone:_____

Work Phone: _____Employer:_____

Lives with patient full time? (circle one) Yes / No If no, please provide address:_____

Insurance: Primary policy: _____Policy Holder: _____

Secondary insurance:_____Policy Holder:_____

Emergency Contact (other than parent): Name:_____Phone #:_____

Besides parents/guardian listed above, who has permission to bring your children to Hartman Pediatrics and consent to treatment?

Name:_____Telephone:_____ Relationship to Patient_____

By signing below, I give my consent for my child/children listed to receive treatment including routine vaccinations and any necessary lab testing as discussed at each visit.

Name: _____

Signature:_____Date:_____

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