TRESTLEWOOD PEDIATRICS

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Patient Demographics

Name of Children (First and Last Name)	**DOB**	**Sex**	**Preferred Name**	**Pronounced As**	**Child's Cell #**
1.					
2.					
3.					
4.					
5					

Is there a court order for any of your children regarding legal, financial, or physical custody? Yes __ No _
Do child/children live with both parents? **Yes** _ **No** _ If not, who is the legal guardian? ____________________

Parent Information

Parent/Guardian #1	**Parent/Guardian #2**
Name (*first and last*):	**Name (*first and last*):**
Name of Spouse:	**Name of Spouse:**
Rel. to Patient:	**Rel. to Patient:**
Address:	**Address:**
City: State: Zip:	**City: State: Zip:**
Cell phone: DOB:	**Cell phone: DOB:**
Home phone:	**Home phone:**
Email address:	**Email address:**
Is this child's primary address? Yes No	**Is this child's primary address? Yes No**

What is the preferred phone number for text appointment reminders? ____________________________________
If text reminders are not an option, please provide an email or phone number ______________________________

Insurance Information

Subscriber's Name	**Sub DOB**	**Rel. to Child**	**Insurance**	**Contract, Policy or ID #**	**Group #**	**Co-Pay**
1.						**$**
2.						**$**

Emergency Contact (Other Than Parent)

Name ________________________________ Phone ____________________ Relationship to Patient _____________

Name of person(s) that you authorize to obtain medical care or your children (medical care may include: immunizations, in-office procedures and injections, in the event a parent cannot bring the child to the appointment, etc.)

Name	**Relationship to Child**	**Phone #**

If you wish to give your older child permission to bring them self, please read and initial below:
______ Trestlewood Pediatrics, P.C., has my permission to treat my child for wellness with possible immunizations and illnesses, as they are able to bring themselves to the appointment.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby assign to Trestlewood Pediatrics, P.C., all payments for medical benefits rendered to the patients listed on this form. I am responsible for any amount not covered by insurance.

Signature: ____Date: ___________________________

Date Reviewed: ______________ Staff Initials: ______________

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