Pediatrics
"TLC for your kids."

(PLEASE LIST CHILDREN FROM OLDEST TO YOUNGEST)

FAMILY INFORMATION SHEET

PATIENT NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	☐ MALE ☐ FEMALE
NICKNAME	SOCIAL SECURITY NUMBER	SCHOOL NAME		GRADE

PATIENT NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	☐ MALE ☐ FEMALE
NICKNAME	SOCIAL SECURITY NUMBER	SCHOOL NAME		GRADE

PATIENT NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	☐ MALE ☐ FEMALE
NICKNAME	SOCIAL SECURITY NUMBER	SCHOOL NAME		GRADE

PATIENT NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	☐ MALE ☐ FEMALE
NICKNAME	SOCIAL SECURITY NUMBER	SCHOOL NAME		GRADE

PATIENT NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	☐ MALE ☐ FEMALE
NICKNAME	SOCIAL SECURITY NUMBER	SCHOOL NAME		GRADE

HOME / MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

RESPONSIBLE PARTY INFORMATION

☐ *FATHER* ☐ *STEPFATHER* ☐ *GUARDIAN*

NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME / MAILING ADDRESS	CITY	STATE		ZIP CODE
EMPLOYER	OCCUPATION	HOME PHONE ( )		WORK PHONE ( )
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE (OR OTHER) ( )

☐ *MOTHER* ☐ *STEPMOTHER* ☐ *GUARDIAN*

NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME / MAILING ADDRESS	CITY	STATE		ZIP CODE
EMPLOYER	OCCUPATION	HOME PHONE ( )		WORK PHONE ( )
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE (OR OTHER) ( )

INSURANCE INFORMATION

INSURANCE COMPANY NAME	MEMBER NUMBER	GROUP NUMBER		CO-PAY	DEDUCTABLE
CLAIMS ADDRESS	CITY	STATE	ZIP CODE	INS. PHONE ( )	
POLICY HOLDER *(FULL NAME)*	DATE OF BIRTH	SOCIAL SECURITY NUMBER		RELATIONSHIP TO PATIENT	

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME	MEMBER NUMBER	GROUP NUMBER		CO-PAY	DEDUCTABLE
CLAIMS ADDRESS	CITY	STATE	ZIP CODE	INS. PHONE ( )	
POLICY HOLDER *(FULL NAME)*	DATE OF BIRTH	SOCIAL SECURITY NUMBER		RELATIONSHIP TO PATIENT	

Are there any additional insurance policies for this patient? ☐ YES ☐ NO

EMERGENCY INFORMATION

NAME OF RELATIVE OR AUTHORIZED PERSON TO NOTIFY IN CASE OF AN EMERGENCY		RELATIONSHIP		HOME PHONE ( )
STREET ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ( )