Healthy Days
PEDIATRICS

Dr. Alison Days

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PATIENT DEMOGRAPHICS

Patient/Child_____
Last First Middle *Nickname*

Date of Birth_____ Male/Female Preferred Language_____

Address_____
Street City State Zip

Home Phone_____ Cell_____ Work_____

Race/Ethnicity (circle) White Native American Black/African American Hispanic/Latino Asian Other_____

Mother_____
Last First Middle *Nickname*

Social Security#_____ Date of Birth_____ Email_____

Address_____

Home Phone_____ Cell_____ Work_____

Employer_____ Employer Address_____

Preferred Language_____

Race/Ethnicity (circle) White Native American Black/African American Hispanic/Latino Asian Other_____

Father_____
Last First Middle *Nickname*

Social Security#_____ Date of Birth_____ Email_____

Address_____
Last First Middle *Nickname*

Home Phone_____ Cell_____ Work_____

Employer_____ Employer Address_____

Preferred Language_____

Race/Ethnicity (circle) White Native American Black/African American Hispanic/Latino Asian Other_____

Patient Name_____ **Date of Birth**_____

Siblings

Name	Relationship	Date of Birth

Other Legal Guardian or Financially Responsible Person

_____

Last Name First Name Middle Name Relationship/Title

Social Security#_____ Date of Birth_____ Email_____

Mailing Address_____

Home Phone_____ Cell_____ Work_____

Employer_____ Employer Address_____

Emergency Contact Name_____ Relationship_____

Address_____

Street City State Zip

Phone Number (1)_____ Phone Number (2)_____

Authorization to Treat and/or Discuss Treatment or Results and/or Procedures

(allows others to bring child into office and/or receive results or follow-up instructions)

I,_____ authorize the following people to consent to evaluation and treatment of above named patient, including patient if listed and patient is at least thirteen (13) years of age:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Are there any custodial issues that impact authorization of medical care? Yes_____ No_____

If yes, please explain_____

_____

Authorized Signature_____ **Date**_____