Today's Date: _____

EASTERN PEDIATRICS, P.A.

Reset Form

1901 Stonehenge Drive • Greenville, NC 27858 • Phone (252) 561-7777 • Fax (252) 561-7778

Patient Information (List all children in family)

Full Name (First Middle Last)	Sex (M/F)	Date of Birth	Race (ex: Caucasian; Asian; African American; Native American)	Ethnicity (Hispanic, Latino)	Preferred Language

Parental Information

Mother/Legal Guardian

Name: _____
Date of Birth (mm/dd/yyyy): _____
Address: _____
_____
Home phone: _____
Work phone: _____
Cell phone: _____
Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Father/Legal Guardian

Name: _____
Date of Birth (mm/dd/yyyy): _____
Address: _____
_____
Home phone: _____
Work phone: _____
Cell phone: _____
Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

- With whom do the children live ? ☐ Both parents ☐ Mother ☐ Father ☐ Other (specify):_____
- In the case of **divorce or other legal custody issue**, is there a legal or court-ordered custody agreement or arrangement involving any of the children listed above? ☐ Yes ☐ No
- **If yes**, please provide our practice a **copy of the agreement** so that we may be better able to provide services to you and your family.
- Would you like to receive appointment reminders via email or text message? ☐ Yes ☐ No
  Email: _____ Cell Phone: _____
- How did you hear about our practice?
  ☐ Internet search ☐ Social media ☐ Saw an ad ☐ Community event ☐ Personal recommendation
  ☐ Other (please describe): _____

Insurance Information (You'll be asked for your insurance card at each visit)

Insurance company: _____
Effective date: _____
Policy number: _____
Group number: _____

Employer: _____
Employee's name: _____
Employee SS Number: _____
Employee's DOB(mm/dd/yyyy): _____

Emergency Contact (Other than parent)

Name: _____ Relationship: _____
Home phone: _____ Cell phone: _____ Work phone:_____

Mother / Legal guardian Signature _____ **Date** _____

Father / Legal guardian Signature _____ **Date** _____

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AUTHORIZATION TO TREAT MINOR CHILD NOT ACCOMPANIED BY PARENT OR GUARDIAN

This authorization is for patients under 18 years of age.

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, friend, sitter, etc., please fill out the following information for us to include in your child's records.

Patient Name: _____ **Date of Birth:** _____

__ Yes __ No **Patient listed above may present and be treated unaccompanied by an adult.**

The following person(s) have my permission to authorize medical services for my child (children) and sign any necessary waivers on my behalf.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

Signature of parent or legal guardian: _____

Date: _____

This authorization will be in affect until changed by parent or legal guardian above.