Patient Demographics

Date completed____________

P a t i e n t

Last name First Middle Date of birth

❑Male ❑Female
Gender

❑African American ❑Asian ❑Caucasian ❑Filipino ❑Hispanic ❑Native American ❑Pacific Islander ❑Other ❑Decline to state
Ethnicity (may check more than one); requested by State of California

( )
Phone

Address City State ZIP

Which adults does the patient live with? (Check all that apply)
❑Mother ❑Father ❑Guardian ❑Step-father ❑Step-mother ❑Other (specify) ______________________________

P a r e n t / G u a r d i a n

Relationship to patient: ______________________

Last name First Middle Date of birth

❑Married ❑Single ❑Separated ❑Divorced
Marital status

Step-parent's name if applicable

Address ❑same as patient City State ZIP

( ) Home Phone
( ) Cell Phone
( ) Work Phone

Employer Occupation

P a r e n t / G u a r d i a n

Relationship to patient: ______________________

Last name First Middle Date of birth

❑Married ❑Single ❑Separated ❑Divorced
Marital status

Step-parent's name if applicable

Address ❑same as patient City State ZIP

( ) Home Phone
( ) Cell Phone
( ) Work Phone

Employer Occupation

E m e r g e n c y C o n t a c t (other than parents)

Last name First Relationship to Patient

( ) Home Phone
( ) Cell Phone
( ) Work Phone

A u t h o r i z e d A d u l t s (other than parents)

I give permission for the following adults to bring the patient for medical care and sign for necessary medical treatment (for example, immunizations) if I, the parent/guardian, am not present. This authorization will be valid indefinitely unless I indicate otherwise. I may change this list at any time.

Parent/Guardian Signature Date

Name of authorized adult	**Relationship to patient**

Patient Contact Preferences

Date completed___________

Patient

Last name ____ First ____ Middle ____ Date of birth ____

Contact # 1 (Primary) *this person will be contacted by our office first*

Name ____ Relationship to patient ____

Home Email* ____ Work Email ____

***Important: In order for you to access the Patient Portal (includes online access to your child's visit history, immunizations, lab results, etc.), you must provide at least one valid email address.**

How would you ideally prefer to be contacted regarding the following? (circle one) Email is preferred ☺

Medical issues:	Home email	Work email	Home phone	Work phone	Cell phone	Text to cell
Appointment reminders:	Home email	Work email	Home phone	Work phone	Cell phone	Text to cell
Recall notices:	Home email	Work email	Home phone	Work phone	Cell phone	Text to cell
General practice notices:	Home email	Work email	Home phone	---	Cell phone	Text to cell
Patient portal notifications:	Home email	Work email	---	---	---	Text to cell

Contact # 2 *this person will be contacted if Contact #1 cannot be reached*

Name ____ Relationship to patient ____

Home Email ____ Work Email ____

If Contact #2 will need to be notified in addition to Contact #1 for medical issues, appointment reminders, recall notices, general practice notices, and patient portal notifications, circle their preferences here:

How would you ideally prefer to be contacted regarding the following? (circle one) Email is preferred ☺

Medical issues:	Home email	Work email	Home phone	Work phone	Cell phone	Text to cell
Appointment reminders:	Home email	Work email	Home phone	Work phone	Cell phone	Text to cell
Recall notices:	Home email	Work email	Home phone	Work phone	Cell phone	Text to cell
General practice notices:	Home email	Work email	Home phone	---	Cell phone	Text to cell
Patient portal notifications:	Home email	Work email	---	---	---	Text to cell

Parents who are divorced or separated: *please fill out this section*

May all contacts have access to the patient's records electronically? ❑Yes ❑No

Who has custody? ____ Name(s) ____ Relationship to Patient

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ❑Yes ❑No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

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