THE CHILDREN'S CLINIC

PATIENT INFORMATION / HEALTH ASSESSMENT

PLEASE PRINT CLEARLY

Child's Name *(First, Middle, Last)* [ ] Male [ ] Female	**Child's Date of Birth** *(dd/mm/yyyy)*:
Place of Birth:	Child's Birth Weight:
Mother's Name *(First, Middle, Last)*:	Father's Name *(First, Middle, Last)*:
P.O. Box:	P. O. Box:
Street Address / House No:	**Street Address / House No**:
Home Phone:	**Home Phone**:
Work Phone (with Ext.):	**Work Phone (with Ext.)**:
Cell Phone:	**Cell Phone**:
E-mail address:	**E-mail address**:
Date of Birth *(dd/mm/yyyy)*:	**Date of Birth** *(dd/mm/yyyy)*:
Place of Employment:	**Place of Employment**:
Insurance Company (If child is /will be enrolled):	**Insurance Company** (If child is /will be enrolled):
Group / Policy Number:	**Group/Policy Number**:
ID/Certificate Number:	ID/Certificate Number:
Is Mom the policy holder? Yes [ ] N0 [ ]	Is Dad the policy holder? Yes [ ] N0 [ ]
Additional Patient Information	
Pre-Natal Complications:	Allergies:
Hospitalization:	Family History
Current Medications:	
Child lives with: [ ] Both Parents [ ] Mother [ ] Father [ ] Other:	
Name/ age of other siblings:	
Name of person who referred you:	Phone No: