ESTABLISHED PATIENT UPDATE OF INFORMATION

Child 1: Last Name: _____ First Name: _____ MI: _____
D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Child 2: Last Name: _____ First Name: _____ MI: _____
D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Child 3: Last Name: _____ First Name: _____ MI: _____
D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Child 4: Last Name: _____ First Name: _____ MI: _____
D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

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Contact Information

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number:_____ Is this a cell phone? Yes / No Address: _____

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email / Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email
Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email
General Practice Notices: Home Address / Home Phone / Cell Phone / Email
Patient Portal Notifications: Cell Phone / Email

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number:_____ Is this a cell phone? Yes / No Address: _____

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email / Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email
Appointment Reminders: Home Phone / Cell Phone / Email
Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email
General Practice Notices: Home Address / Home Phone / Cell Phone / Email
Patient Portal Notifications: Cell Phone / Email

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____
2: _____ Relationship _____ Phone: (___) _____ - _____
3: _____ Relationship _____ Phone: (___) _____ - _____
4: _____ Relationship _____ Phone: (___) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

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

If no, list who <u>may</u> have access_____

If parents are divorced or separated please fill out this section:
Who has custody? _____

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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