Azalea Pediatrics

6801 River
Road Suite 401
Columbus, GA 31904
762-208-505

Patient and Family Information

Child 1: Last Name: _____ First Name:_____MI: ___

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline

Child 2: Last Name:_____First Name:_____MI: ___

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 3: Last Name:_____First Name:_____MI: ___

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

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Child 4: Last Name:_____First Name:_____MI: ___

DOB:____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Pharmacy Name:_____ Pharmacy Phone #: _

Azalea Pediatrics

Parent/Legal Guardian #1:

Child(ren)'s parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widow(er) ☐ Other

Name:_____Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone:_____Email: _____

Employer:_____Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐ Work

AZALEA PEDIATRICS may contact me via: ☐ Home ☐ Cell ☐Work ☐ Email

AZALEA PEDIATRICS may leave messages or lab results via: ☐ Home ☐Cell ☐ Work ☐ Email

Lives with patient? Yes / No

_____

(Street) *(City/State/Zip)*

Parent/Legal Guardian #2:

Name: _____ Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone:_____Email: _____

Employer:_____Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐ Work

AZALEA PEDIATRICS may contact me via: ☐ Home ☐ Cell ☐Work ☐ Email

AZALEA PEDIATRICS may leave messages or lab results via: ☐ Home ☐Cell ☐ Work ☐ Email

Lives with patient? Yes / No If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1):

Azalea Pediatrics

(Street) *(City/State/Zip)*

Additional Contact Questions:

Who should receive billing statements? _____

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

If parents are divorced, separated or unmarried, 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.

_____

_____

Emergency Contacts, other than parents. Name & Relationship:

Name:_____Phone: _____

Name:_____Phone: _____