Patients: Legal First Name:_________________________ Legal Last Name:______________________________
Preferred: ______________________ DOB:________________ Male/ Female

Race:
[ ] White
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] Asian
[ ] American Indian or Alaska Native
[ ] Decline
[ ] Other_________________

Ethnic Group:
[ ] Hispanic or Latino
[ ] Not Hispanic or Latino
[ ] Decline

Mailing Address:_______________________________ City:___________________ State:_____ Zipcode:_______
Email:____

Mother:____________________________________ DOB:_____________
Phone:(   ) _____-_______

Father:____________________________________ DOB:______________
Phone:(   ) _____-_______

Legal Guardian:______________________________ DOB:______________
(If different than above)

Emergency Contact:_____________________________________ Phone:(   ) _____-_______
(Someone not living in the home)

Primary Insurance:____ Subscriber:__________________________
Policy Number:______________________________________ Group Number:__________________________

Secondary Insurance:____ Subscriber:__________________________
Policy Number:______________________________________ Group Number:__________________________

Medical History:
____
____
Current Medications:____
Allergies/ Adverse Reactions to Medications: ____

I hereby authorize all doctors, assistants, or auxiliaries associated with Color Country Pediatrics to complete any necessary treatments on my child or patient that I am responsible for. I have read all the above information and completed it to the best of my knowledge.

Signature Parent/Guardian:_________________________________ Relationship:__________ Date:___________