



Child's Full Name: \_\_\_\_\_  
First M Last

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Phone

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Child resides with:  both parents  mother  father  other \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk. Phone: ( ) \_\_\_\_\_

Address:  same as above OR Home Phone: ( ) \_\_\_\_\_

Address City State Zip

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk. Phone: ( ) \_\_\_\_\_

Address:  same as above OR Home Phone: ( ) \_\_\_\_\_

Address City State Zip

**Emergency Contact (other than parent):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

**Pharmacy Information:**

Name of Pharmacy: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Cross Streets: \_\_\_\_\_ / \_\_\_\_\_

How did you hear about Pendleton Pediatrics?  
\_\_\_\_\_

(Initial box) I have received and understand the Pendleton Pediatrics HIPAA policy.

(Initial box) I have received a copy of the Financial Policy **and** understand my financial responsibility.

**CONSENT TO TREAT:**

I, acting as a guardian to the above named patient, hereby give my consent for the above patient to receive medical evaluation and treatment by the provider's at Pendleton Pediatrics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_