Families First Pediatrics
Patient Agreement/ Family Addition

Name of Children	Sex	Date of Birth	Race	Preferred Language	Patient Lives With
1. _____	M F	_____	_____	_____	_____
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					
2. _____	M F	_____	_____	_____	_____
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					
3. _____	M F	_____	_____	_____	_____
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					
4. _____	M F	_____	_____	_____	_____
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					

Father Name_____ Mother Name_____

Home Phone_____ Cell _____ Home Phone_____ Cell_____

Wk. Phone_____ Employer _____ Wk. Phone_____ Employer _____

Emergency Contact other than immediate family _____ Phone_____

Relationship to Patient _____

How did you hear about our office? Friend/Family: _____ Hospital Mailer Website Other_____

INSURANCE INFORMATION (PROOF OF INSURANCE IS REQUIRED)

(If proof of insurance is not available, patient will be considered not insured until proof is shown.)

Primary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____Policy Holder SS#: _____

If you are not able to provide a copy of the insurance card, please fill out the following:

Insurance Address: _____

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Insurance Phone #: _____ Insurance ID#:_____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____Policy Holder SS#: _____

If you are not able to provide a copy of the insurance card, please fill out the following:

Insurance Address: _____

Insurance Phone #: _____ Insurance ID#:_____ Group #: _____

I allow the following people to bring my child/children in for appointments & make medical decisions in my behalf:

_____ _____ _____

Signature: _____ Printed Name: _____Date: _____