Patient Information (Child/ Adolecent) : *Required fields Chart # _____ (office use only)

***Child's Name:**_____(_____)
Last First Middle (**Preferred Name**)

***Social Security**:_____ * **Birthdate**:_____

***Mailing Address:**_____ **City** _____**State**_____ **Zip**_____

***Home Phone:**_____ **Cell Phone**:_____ **Work Phone:** _____

***Parent/Legal Guardian:**_____ **Social Security Number**: _____

***Mailing Address:**_____ **City** _____**State**_____ **Zip**_____

***Parent's Date of Birth** _____ Employer Name & Address:_____

Please circle all that apply to the patient:

***Sex:** Male Female ***Gender:** Male Female TransMTF TransFTM Other

***Sexual Oreintation:** Straight Gay/Lesbian Bisexual Don't Know Other

***Marital Status:** Single Married Divorced Seperated Widow Life Partner

***Race:** Caucasion (white) Hispanic Black/African American Pacific Islander Asian Other

***Ethnicity**: Hispanic/Latino Non-Hispanic/Lantino ***Veteran**: Yes No ***Student:** Yes No

***Homeless:** Yes No ***Migrant Worker:** Yes No ***Spouse Employed:** Yes No

***Preferred Language:** English Spanish Other: _____

How do you wish to receive appointment reminders?

Phone: _____ Email: _____

Text Message to Cell Number: _____ Mobile Carrier:_____

***What is your household income?** ☐ **Less than $30,000 per year** ☐ **More than $30,000 per year**

Primary Insurance Information:	**Secondary Insurance Information:**
Name of Insurance Company:_____	Name of Insurance Company:_____
Policy # _____ Group #_____	Policy # _____ Group #_____
Policy Holder:	Policy Holder:
* Name_____	* Name_____
*Date of Birth ___/__/_____	*Date of Birth ___/__/_____
Please provide a copy of your insurance card.	**Please provide a copy of your insurance card.**

_____ _____

Signature of Patient or Authorized Person Date