5716 Jackson Street
Alexandria, LA 71303

Ph. 318-767-6503
Fax. 318-703-8257

Patient and Family Information

Child 1: Last Name:_____ First Name:_____ MI: ____

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

Race: ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Hawaiian or Pacific Islander

☐ Native American or Native Alaskan ☐ Other _____ ☐ Decline

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

Child 2: Last Name:_____ First Name:_____ MI: ____

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

Race: ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Hawaiian or Pacific Islander

☐ Native American or Native Alaskan ☐ Other _____ ☐ Decline

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

Child 3: Last Name:_____ First Name:_____ MI: ____

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

Race: ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Hawaiian or Pacific Islander

☐ Native American or Native Alaskan ☐ Other _____ ☐ Decline

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

Child 4: Last Name:_____ First Name:_____ MI: ____

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

Race: ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Hawaiian or Pacific Islander

☐ Native American or Native Alaskan ☐ Other _____ ☐ Decline

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

Pharmacy Name:_____ Pharmacy Phone #: _____

Parent/Legal Guardian #1:

Name:_____Relationship to Patient: _____

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

Work phone:_____Email: _____

Employer:_____Occupation: _____

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

JACKSON STREET PEDIATRICS may contact me via: ☐ Home ☐ Cell ☐ Work ☐ Email

JACKSON STREET 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

JACKSON STREET PEDIATRICS may contact me via: ☐ Home ☐ Cell ☐ Work ☐ Email

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

Lives with patient? Yes / No

_____

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

Additional Persons that may Bring Child to Visits/Consent to Medical Care:

Name:_____ Relationship to Patient:_____

Phone:_____

Name:_____ Relationship to Patient:_____

Phone:_____

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 to Patient:_____

Phone:_____

Name:_____ Relationship to Patient:_____

Phone:_____