Date:

Name: **Parent/ Guardian:**
(if patient is a minor)

Preferred Name: [redacted]

FULL SSN: _____ **Date of Birth: _____**

Preferred Contact Number: _____ **Home ____ Cell ____ Work ____**

Alternate Contact Number: _____ **Home ____ Cell ____ Work ____**

It will be necessary to contact you regarding your care. What method of communication do you prefer? (Check all that apply.)

☐ Telephone (May we leave a message? ☐ Y ☐ N) ☐ Mail ☐ Email ☐ Text

Mailing Address: _____

_____

Email address: _____

Primary care physician: _____ **Phone #:**_____

If your child was referred by a school, please provide the name of the school so we may forward the results:

_____

Please list anyone, *other than your emergency contact and referring provider*, with whom your personal health information can be shared.

1. _____ **2.** _____

Emergency Contact: _____ **Relationship:** _____

Contact Number: _____

The emergency contact will be notified in case of a health or safety emergency that may occur while you are at our facility.