TRINITY PEDIATRICS, P.C.
NEW PATIENT INFORMATION FORM

Patient's name ____________________________________ boy / girl Date of Birth________________

Address ____ City _____________________________

State________________ Zip code___________ Social security number ____________________________

Home Phone#___________________________

Emergency Contact Information

Name ____ Relationship to patient ______________________

Phone Number# ________________________________

Parent/Guardian Information

Name______________________________ Maiden name________________ Date of birth____________

Social security number______________________________ Phone number#________________________

Place of Employment_______________________________ Work number# _________________________

OFFICE VISITS

Others allowed to bring child to office. (Must have ID with them)

PRINT NAME	RELATIONSHIP	DOB	TELEPHONE #

I _____________________________________being the parent guardian of_________________________, hereby allow TRINITY PEDIATRICS, P.C. to treat my child if brought in by any of the above stated persons including myself. I accept the responsibility of informing the clinical staff of any changes needed to this form.

________________________________ ___________ ___________________________ __________
Parent/Guardian Signature Date Witness Signature Date