

Gabriel Pediatrics, PC

Date _____

New Patient Change of Information

Patient Registration

Patient's Full Name	Date of Birth	Sex (circle one) Male Female
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander		

Mother/Legal Guardian's Information

Full Name (including Maiden Name)		Date of Birth
Physical/Permanent Address		Mailing Address (If different from Physical Address)
Home Phone	Cell Phone	Social Security Number
Email Address		
Employers' Name and Address		Occupation
Work Phone Number	Ext.	Responsible Party's Relationship to Patient (circle one) Mother Father Guardian Other

Father/Legal Guardian's Information

Full Name		Date of Birth
Physical/Permanent Address		Mailing Address (If different from Physical Address)
Home Phone	Cell Phone	Social Security Number
Email Address		
Employer's Name and Address		Occupation
Work Phone Number	Ext.	Responsible Party's Relationship to Patient (circle one) Mother Father Guardian Other

Whom may we thank for referring you? _____

If parents are divorced who has legal custody of child? _____

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

I authorize the staff of GABRIEL PEDIATRICS, PC, to leave medical information pertaining to the patients care by the following methods and will assume responsibility to notify them whenever this information changes:

____ Home Telephone/Answering Machine/Fax ____ Work Telephone/Voice Mail/Fax ____ Cellphone/Voice Mail

Please list names of authorized people we may leave messages with: (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc.)

Names and Relationships

Please list names of authorized people we may discuss your financial situation with:

Names and Relationships

Signature (Patient/Guardian) _____ Date _____