

REDWOOD PEDIATRIC & ADOLESCENT MEDICINE
Patient Information Sheet

Today's Date: _____

Patient Info

*denotes a required field

*Patient Name: _____ *Sex: _____ *Date of Birth: _____

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

*** **If 18 or over:** Patient phone _____ Patient e-mail _____

Ethnicity (please circle one): **Hispanic / Not Hispanic** Preferred Pharmacy: _____

Race (please circle one): **Am Indian or Alaskan Native / Asian / Black or African Am / Nat Hawaiian or Pacific Islander / Other / White**

Parent Info

****Parent/Guardian# 1 will be considered the primary contact for the patient and will receive correspondence, statements and phone calls etc. unless we are informed otherwise.**

**Parent/Guardian #1: _____ *Relationship to Patient: _____ *Date of Birth: _____

*Address (if different): _____ *City: _____ *State: _____ *Zip: _____

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

*e-mail: _____

Parent/Guardian #2: _____ *Relationship to Patient: _____ *Date of Birth: _____

*Address (if different): _____ *City: _____ *State: _____ *Zip: _____

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

Primary Insurance

*Policy Holder's Name: _____ *Date of Birth: _____ *Telephone: _____

SocSec#: _____ *Relationship to Patient: _____ *Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co. Phone: _____

*Subscriber ID#: _____ *Group #: _____

Secondary Insurance

*Policy Holder's Name: _____ *Date of Birth: _____ *Telephone: _____

SocSec#: _____ *Relationship to Patient: _____ *Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co. Phone: _____

*Subscriber ID#: _____ *Group #: _____

*** **Preferred Method of Receiving Appointment Reminders (please check ONLY one):**

Text: _____ Cell # _____

Email: _____ Email address: _____

Voice: _____ Phone# _____ (is this a cell #? **Yes** or **No**)