



**Patient and Family Information**

**Child 1:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Preferred Language: \_\_\_\_\_

Race:  African American  American Indian or Native Alaskan  Asian  
 Hawaiian or Pacific Islander  White  Other  Decline

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

**Child 2:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Preferred Language: \_\_\_\_\_

Race:  African American  American Indian or Native Alaskan  Asian  
 Hawaiian or Pacific Islander  White  Other  Decline

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

**Child 3:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Preferred Language: \_\_\_\_\_

Race:  African American  American Indian or Native Alaskan  Asian  
 Hawaiian or Pacific Islander  White  Other  Decline

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

**Child 4:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Preferred Language: \_\_\_\_\_

Race:  African American  American Indian or Native Alaskan  Asian  
 Hawaiian or Pacific Islander  White  Other  Decline

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

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

**Parent/Legal Guardian #1:**

Child(ren)'s parents are:  Married  Divorced  Never Married  Separated  Widow(er)  Other

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Best number to reach me is:  Home  Cell  Work

Goldstar Pediatrics may contact me via:  Home  Cell  Work  Email  Portal

Goldstar Pediatrics may leave messages or lab results via:  Home  Cell  Work  Email  
 Portal Initials \_\_\_\_\_

Lives with patient? Yes / No If you do not live with the patient, please provide the address:

\_\_\_\_\_  
(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

Goldstar Pediatrics may contact me via:  Home  Cell  Work  Email  Portal

Goldstar Pediatrics may leave messages or lab results via:  Home  Cell  Work  Email  
 Portal Initials \_\_\_\_\_

Lives with patient? Yes / No If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1):

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City/State/Zip)

**Additional Contact Questions:**

Who should receive billing statements? \_\_\_\_\_

May all contacts have access to the patient's records? Yes / No

If parents are divorced or separated 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:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_