Victoria Pediatrics and Adolescent Assoc.

Dr. Felix F. Regueira

Patient Information Form

(Please print clearly and complete all blanks)

Date_____

_____Sex_____DOB___/___/____

Patients name

SS#_____ Allergies_____

Preferred Pharmacy:_____Address_____Phone_____

Mother's Name_____DOB___/___/___SS #_____

Home address_____Zip_____ _____

Employer Name_____Email _____

Home Phone #_____Work #_____Cell #_____

Father's Name_____DOB___/___/____SS #_____

Home address if different from mother's:_____

Phone numbers: Home #_____W#_____Cell#_____

Employer Name_____ Work Phone #_____

Child's Primary legal custodian: (check one) ____Mother ____Father ____Grandparent____Other_____

Race-Check one: White_____Hispanic_____African American_____Asian_____Refused to report_____

Ethnicity-Check one: Hispanic or Latino_____ Not Hispanic or Latino_____Refused to report_____

Language-Check one: English_____Spanish_____Other_____

Translator requested: _____declined_____

Insurance Information—Primary:

Policy Holder's Name_____DOB___/___/____

Relationship to child_____Name of Plan_____

Claims Address_____Phone #_____

Policy Number_____Group Number_____

Insurance Information—Secondary:

Policy Holder's Name_____DOB___/___/____

Relationship to child_____Name of Plan_____

Claims Address_____Phone #_____

Policy Number_____Group Number_____

Emergency Contact:

Name_____Relationship to patient_____

Phone #1_____ Phone #2_____

Signed: (Parent or Guardian if Minor)_____date___/___/___