DR. PARRINGTON, DR.FREEMAN & DR. LAM
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PATIENT INFORMATION SHEET

CHILD'S FULL NAME____
FIRST MIDDLE LAST

BIRTH DATE______________ SEX_____RACE_____BIRTH WEIGHT_____________

DELIVERY DR ____________________________HOSPITAL______________________

ALLERGIES TO MEDICATIONS______________SPECIFY WHICH ONE(S) ______________

WHO REFERRED YOU TO OUR OFFICE? ____

DO YOU HAVE OTHER CHILDREN THAT HAVE BEEN SEEN HERE? _______________

PARENTS MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

FATHERS NAME____
FIRST MIDDLE LAST
ADDRESS____APT#__________

CITY___________________STATE______ZIP_________HOME PHONE_____________

OCCUPATION_____________________________EMPLOYER_______________________

SOCIAL SECURITY#_________________________DATE OF BIRTH________________

WORK PHONE____________________EXT______MOBILE PHONE_________________

MOTHERS NAME____
FIRST MIDDLE LAST
ADDRESS____APT#_____________

CITY____________________STATE_____ZIP________HOME PHONE_______________

OCCUPATION_______________________________EMPLOYER_____________________

SOCIAL SECURITY#________________________DATE OF BIRTH_________________

WORK PHONE____________________EXT_____MOBILE PHONE__________________

EMERGENCY INFORMATION, PERSON TO CONTACT IF WE CANNOT REACH A PARENT

NAME_________________________	NAME___________________________
ADDRESS______________________	ADDRESS________________________
HOME NUMBER_________________	HOME NUMBER_________________
WORK NUMBER________________	WORK NUMBER________________

SIGNATURE OF PARENT OR GUARDIAN AUTHORING TREATMENT OF MINOR

SIGNED____DATE_________________________