# PREFERRED PEDIATRICS P.A.
# OLATHE

**PATIENT INFORMATION:**

(circle one)

Child's Legal Name:______________________________ Sex: **M** **F**

Child's nickname: ______________________________ Birth Date: ______________

Address: Street: ______________________________ Apt. ______________

City:______________ State: ______ Zip: ______________ Phone:______________

Email Address: ______________________________

**FAMILY INFORMATION:**

Child is living with: (circle one) Both Parents One Parent Alone

Parent and Step Parent Other ______________

Who is responsible for account? ______________________________

Father's Name:______________________________ Home Phone:______________

Employer: ______________________________ Work Phone: ______________

Mother's Name: ______________________________ Home Phone:______________

Employer:______________________________ Work Phone:______________

Emergency Contact: ______________ / ______________ / ______________

Name Relationship Phone #

Please list other children living in the household:

| Name | Birth Date |
|---|---|
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**CONSENT** is hereby given to perform any and all examinations, tests, procedures, and treatments necessary and/or advisable; and in an emergency, without the presence of parents or responsible adults. I AUTHORIZE Preferred Pediatrics P.A. to file insurance claims for services and supplies rendered to and for my child and I ASSIGN to Preferred Pediatrics P.A. all payments for medical services rendered to my dependent child(ren). I also authorize Preferred Pediatrics P.A. to **RELEASE INFORMATION**, including my child's medical and billing information, to my referring doctor, insurance company, or the responsible party named above.

Signed: X______________________________ Date:______________

Whom may we thank for referring you? ______________________________