# OMEGA PEDIATRICS INTAKE Date:

## Patient information

### PATIENT INFORMATION

| LAST NAME | FIRST NAME | M.I. | DOB: | AGE |
|---|---|---|---|---|
| | | | | |

| MAILING ADDRESS: | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| PATIENT IS (CIRCLE ONE) MALE FEMALE | PATIENT'S SCHOOL | COUNTY |
|---|---|---|
| | | |

| EMERGENCY CONTACT NAME | RELATIONSHIP TO PATIENT | PHONE |
|---|---|---|
| | | |

## Mother

### MOTHER'S INFORMATION

| LAST NAME | FIRST NAME | PHONE NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| EMPLOYER NAME/ADDRESS | STATE | ZIP |
|---|---|---|
| | | |

## Father

### FATHER'S INFORMATION

| LAST NAME | FIRST NAME | PHONE NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| EMPLOYER NAME/ADDRESS | STATE | ZIP |
|---|---|---|
| | | |

## Email

EMAIL ADDRESS (UPPERCASE PLEASE)

CAN WE EMAIL MEDICAL INFORMATION HERE

(CIRCLE ONE PLEASE) YES NO

## Race Language

**RACE (Circle one please):**

**AFRICAN AMERICAN/BLACK**

**ALASKAN NATIVE/NATIVE AMERICAN**

ASIAN **HISPANIC** **MIDDLE EASTERN**

**NATIVE HAWAIIAN OR PACIFIC ISLANDER** **WHITE/CAUCASIAN** **I PREFER NOT TO SAY**

**PREFERRED LANGUAGE (Please select one)**

ENGLISH SPANISH

FRENCH OTHER_____

**PREFERRED PHARMACY OF CHOICE (Write full address and phone number if known)**

## Insurance

### PRIMARY INSURANCE INFORMATION

| INSURANCCE COMPANY NAME | EFFECTIVE DATE |
|---|---|
| | |

| PATIENT'S INSURANCE NUMBER: | GROUP NUMBER IF KNOWN |
|---|---|
| | |

RELATIONSHIP TO POLICY HOLDER:

**Signature of parent or legal guardian**_____ **Date**_____