

PATIENT INFORMATION
2011 UPDATE

Child's Name _____ male female **Birthdate** _____
FIRST LAST

Parent #1 Name _____ male female **Occupation** _____
FIRST LAST

Parent #2 Name _____ male female **Occupation** _____
FIRST LAST

Please check appropriate box:

- Parents married and together
- Parents unmarried and together
- Single Parent
- Parents divorced
- One Parent deceased

Who has **legal** custody/authority to consent to your child's medical care and vaccines? _____

Any exposure to cigarette smoke? Yes No

New medical problems? _____

New surgeries? _____

New major injury or trauma? _____

New overnight hospitalizations? _____

SIGNATURE AND RELATIONSHIP TO CHILD DATE

DOCTOR SIGNATURE

DATE

rev 1/25/11