FORESTREAM PEDIATRICS PATIENT INFORMATION FORM

PLEASE PRINT:
PATIENT NAME:_____ **GENDER:** ☐MALE ☐FEMALE **DOB:**_____

ADDRESS:_____

CITY/TOWN:_____ STATE_____ ZIP CODE_____

PHONE HOME: ( ) CELL : ( )

FAX: ( ) WORK: ( )

E-MAIL ADDRESS: _____

Please complete *BOTH Race and Ethnicity*

RACE OF PATIENT
- ☐ WHITE
- ☐ BLACK/AFRICAN AMERICAN
- ☐ AMERICAN INDIAN / ALASKA NATIVE
- ☐ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER
- ☐ OTHER
- ☐ DECLINE
- ☐ UNKNOWN

ETHNICITY OF PATIENT
- ☐ *SPANISH / HISPANIC ORIGIN*
- ☐ *NOT OF SPANISH / HISPANIC ORIGIN*
- ☐ *DECLINE*
- ☐ *UNKNOWN*

PRIMARY LANGUAGE OF PATIENT:_____ COUNTRY:_____

SECONDARY LANGUAGE OF PATIENT:_____ COUNTRY:_____

WILL YOU NEED TRANSLATION/LANGUAGE SERVICES? _____

DO YOU HAVE A HEARING OR VISION IMPAIRMENT THAT WOULD REQUIRE SERVICES (i.e. SIGN LANGUAGE)?

_____

LEGAL GUARDIAN INFORMATION - PLEASE CHECK PARENTAL DESCRIPTION AND LEGAL GUARDIAN IF BOTH APPLY:

☐MOTHER ☐FATHER ☐LEGAL GUARDIAN NAME/ADDRESS:

_____

_____

_____

Mother's Maiden Name: _____

PHONE: Home: ( )
Cell: ( )
Work: ( )

☐MOTHER ☐FATHER ☐LEGAL GUARDIAN NAME/ ADDRESS:

_____

_____

_____

PHONE: Home: ( )
Cell: ( )
Work: ( )

Relationship between Parents or Legal Guardians: ☐ Married ☐ Separated ☐ Divorced ☐ Other

PRIMARY CARE GIVER: _____
(not primary care physician)

WHO HAS LEGAL CUSTODY OF PATIENT:_____

EMERGENCY CONTACT:_____ PHONE: ( )

Relationship to Patient:_____

SIBLINGS (NAME: FIRST/LAST AND DOB) WHO ARE PATIENTS AT FORESTREAM PEDIATRICS:

_____

_____

_____

NAME OF PERSON COMPLETING FORM:_____ DATE:_____

SIGNATURE:_____ **Relationship to patient:**_____