

Inlet Pediatrics
Patient Information

Child's Name

First: _____ MI: _____ Last: _____ Date of Birth: _____

Nickname/Preferred: _____

Sex: Male / Female

Race: (circle one)

American Indian/Alaska Native

Asian

Black/African American

Declined

Native Hawaiian/Pacific Islander

Other Race

Unknown

White/Caucasian

Ethnicity: (circle one)

Declined

Hispanic or Latino

Not Hispanic or Latino

Unknown

Preferred Pharmacy: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Mother Cell: _____ Father Cell: _____ Home Phone: _____

Work Phone/Other: _____ Email Address: _____

Preferred Method of Communication: (circle one)

Declined

Email

Fax

Mail

Other

Phone

Preferred Provider: (circle one)

~~Amanda Drosieko, MD (not accepting new pts)~~

~~Stephen Replenski, DO (not accepting new pts)~~

Robin Hudson, MD

Dawn Fox, CPNP

Tracey Wood, CPNP

No Preference

Parents/Legal Guardian

Lives with child?

Mother: _____ Social Security #: _____ Date of Birth: _____ Y or N

Father: _____ Social Security #: _____ Date of Birth: _____ Y or N

Other: _____ Y or N

Insurance Information

Financially Responsible Person: _____

Primary Insurance Plan: _____

Policy #: _____

Secondary Insurance Plan: _____

Policy #: _____

Who else has permission to bring this child to Inlet Pediatrics and authorize treatment?

Name: _____ Contact Telephone: _____ Relationship to Patient: _____

Name: _____ Contact Telephone: _____ Relationship to Patient: _____

I authorize treatment by Inlet Pediatrics, PA and agree to be responsible for the cost of the services provided by Inlet Pediatrics.

Signature: _____ **Date:** _____