Inlet Pediatrics
Patient Information

Child's Name

First:__________________________ MI:___ Last:____________________ Date of Birth:______________

Nickname/Preferred:________________________

Sex: Male / Female

Race: (circle one)
Amercian 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:_____ Zipcode:_______

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)
Melissa McCabe, MD
Stephen Replenski, DO
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:**_____________________