New Patient Questionnaire

Today's Date: ____________________________

Child's Name: ____

Date of Birth: ____________________________ Child's SS Number: ____________________________

Sex: __________________________ Forms Completed By: __________________________

Relationship to Child: __________________________

Child's Address: ____

City: __________________________________ State: __________ Zip: __________________

PCP (If other than Dr. Garriga): __________________________________

Home Phone: ___________________________ Cell Phone: ______________________________

Mother's Name: __________________________ Phone: __________________________________

Mother's Occupation: ______________________ Mother's DOB: ____________________________

Father's Name: __________________________ Phone: ___________________________________

Father's Occupation: ______________________ Father's DOB: ______________________________

Email: ____________________________________

Parent's Marital Status: Married Divorced Separated Unmarried Widowed

Emergency Contact Name: _________________________ Phone: __________________________

Relationship to Patient: ____

Pharmacy Name: ____

Pharmacy address and phone number: ____

INSURANCE:

Primary Medical Insurance: __________________ Name of Policy Holder: ______________________

Relationship of Policy Holder to Patient: ____

Policy Holder's Address (If different than above): ____

*I understand there will be a $50 out of pocket charge for late cancellations or missed appointments.

_______________________________________ _________________________________

Signature of Parent/Guardian **Date:**