Lowcountry Pediatrics * General Information

Patient Information:

Patient Name: ____________________ ____________________ ____________________
First Middle Last

Date of Birth: ______________

Gender: ____ Male ____ Female County of Residence: ______________________

Patient Address: ____

City: ______________________ State: __________ Zip Code: ______________

Phone Number: ______________________ Patient Social Security #: ______________

Parent Information:

Parent Here With Child Today: ____________________________________
First Middle Last

Parent Address (if different than above): ______________________________

City: ______________________ State: __________ Zip Code: ______________

Parent Email Address: ____

Date of Birth: ______________ Parent Social Security #: ____________________

Parent Gender: ____ Male ____ Female Home Phone#: __________ Cell Phone#: __________

Parent Employer: ______________________ Work # ______________ Fax # ______________

Parent Employer: ____

Parent not listed above: ____
First Middle Last

Parent Address (if different from above) ______________________________

City __________ State ______ Zip Code __________

Parent Social Security # ______________ Date of Birth __________ Gender _____ M _______F

Parent Home#: ______________________ Parent Cell # ______________________

Additional Information:

Emergency Contact (other than either parent): ______________________________

Relationship to child: ______________________ Phone #: ______________________

Step Parent Name (if applicable) ______________________ Phone # ______________

Insurance (please give card to front desk): ______________________________

Name of parent who carries the insurance: ______________________ Date of Birth__ ______________

Language Preferred: ______________________ Race: ______________ Ethnicity: ______________