

MountainStar Ogden Pediatrics Patient Information Sheet

(Please notify our office if any of this information changes)

Patient Information:

Patient's Name: _____

Date of Birth: _____ Sex: Male Female

Social Security Number (SSN): _____

Parent/ Guardian Information: Custody? Yes No Joint

Name: _____

Address: _____

City, State, Zip: _____

Home phone #: () _____ Date of Birth: _____

Social Security Number: _____

2nd Phone #: () _____ Work/Cell: () _____

Relationship: Mother Father Other: _____

Other Parent/Guardian Information: Custody? Yes No Joint

Name: _____

Address: _____

City, State, Zip: _____

Home phone #: () _____ Date of Birth: _____

Social Security Number: _____

2nd Phone #: () _____ Work/Cell: () _____

Relationship: Mother Father Other: _____

Emergency contact: (Person who does not live with the Patient)

Name: _____

Phone Home: () _____ Work/Cell: () _____

Relationship: _____

Name: _____

Phone Home: () _____ Work/Cell: () _____

Relationship: _____

You will be asked for a copy of your **Insurance card** (we will ask for it at every visit).

Signature: _____ **Date:** _____

Signed by (please print): _____

Race (please "✓" only one) American Indian or Alaska Native Asian Native Hawaiian or other Pacific Islander
 Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Other: _____

If you're a NEW PATIENT, how did you hear about our office? _____