Beaches Pediatrics, PA

Rebecca Cooper, MD., J.D.

Date: ________________

Patient name:______________________________ DOB: __________________________ M/F

Address: ___________________________________City________________ZIP__________________

Preferred email address: _____________________________________

Preferred contact number: _________________________ Home phone______________________

Referred by: ____

Prior Physician: ___________________________ Phone #:____________________________

Parent's name: ___________________________ DOB: _________________ SS#_______________

Parent's work #_______________________ cell#_____________________________

Parent's name: ___________________________ DOB: _________________ SS#_______________

Parent's work #_______________________ cell #_____________________________

Who else is authorized to bring your child to appointments _____________________________

Relationship_______________________________Phone #:______________________________

Race (circle one): Native American/Native Alaskan Asian Black/African America
Native Hawaiian/other Pacific Islander White/Caucasian More than one race Decline to respond

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Decline to respond

Preferred Language: _________________________________

Insurance: ________________________________Phone #:_________________________________

Policy holder's name ___________________________________ DOB:_______________________

S.S. #:_____________________ Policy #:________________________ Group #:__________________

Patient's relationship to insurer: Child Self Other

Information for siblings who are also patients here::

Name: ____ DOB__________________________ M/F

Name: ____DOB __________________________ M/F

Name: ____ DOB__________________________ M/F