Diana McLaughlin, M.D., F.A.A.P.
Kids' Medical Care
2336 Immokalee Road, Naples FL 34110
Phone: (239) 591-8481
Fax: (239) 596-0212
www.kidsmedicalcare.com

DATE: _____ **PATIENT INFORMATION** **M.R.#** _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ SS #: _____ Gender: M or F_____

Full Address, City, Zip Code: _____

Cell Phone #1: _____ Cell Phone #2: _____ Email Address: _____

Pursuant to Federal Law please provide the following information. You may refuse by answering "No."

Race: White Native American Indian Black Asian Other_____

Ethnicity: Hispanic Non-Hispanic Other: _____

Language:

Mother or Legal Guardian

Mother's Name: _____

SS#: _____ D.O.B. _____

Driver's License #: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Father or Legal Guardian

Father's Name: _____

SS#: _____ D.O.B. _____

Driver's License #: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

EMERGENCY CONTACT INFORMATION

Please provide the name of someone not living in your household that we may contact in the event of an emergency.

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Address: _____

PRIMARY INSURANCE

Insurance Company Name: _____

Insured's Name: _____ Group Name: _____

ID#: _____ Group #: _____

Address: _____

Insurance Phone #1: _____ Phone #2: _____

SECONDARY INSURANCE

Insurance Company Name: _____

Insured's Name: _____ Group Name: _____

ID#: _____ Group #: _____

Address: _____

Insurance Phone #1: _____ Phone #2: _____

I certify that the above information is correct at this time. I will promptly notify Kids' Medical Care of any changes in the above information.

Date: _____ Parent/Legal Guardian Print: _____ Sign: _____