DOCTORS OF CHILDREN OF ORANGE COUNTY

PATIENT INFORMATION

Meigan Everts, MD Teresa Lee, MD

This information is confidential. We appreciate your filling out this form as completely as possible.

LAST NAME: ___________________________ Who recommended you to us? __________________________

Child's First Name:	**Birth date:**	**M/F:**	**Known Drug Allergy:**	**Obstetrician:**
1. ____________________	___________	_____	______________________	________________________
2. ____________________	___________	_____	______________________	________________________
3. ____________________	___________	_____	______________________	________________________
4. ____________________	___________	_____	______________________	________________________

PLEASE LIST 2 PHONE NUMBERS WHERE YOU CAN BE REACHED DURING THE DAY.

Home #: ____________________ **Mom cell #**: _____________________ **Dad cell #**: ______________________

FATHER: Birthdate: _________________ Age:_____ SSN: ___________________ CDL: __________________

Name Home Address City Zip

Employer Occupation Work Address City Zip Work phone

Medical Insurance Co: _______________________ ID #: ________________ Group #: _____________________

MOTHER: Birthdate: _________________ Age:_____ SSN: ___________________ CDL: __________________

Name Home Address City Zip

Employer Occupation Work Address City Zip Work phone

Medical Insurance Co: _______________________ ID #: ________________ Group #: _____________________

Legal Guardian and/or person(s) with financial responsibility for your children, if other than the parents.

Name: ____

EMERGENCY CONTACT:

Name: ________________________ Relationship:_______________________ Phone #: ___________________