Association of Childcare Physicians, Ltd.

☐ Dr. Shaw ☐ Dr. Kellow

Patient Information

Name of Patient and ALL Siblings (First, Last) Sex Birth date Patient's phone no.

1 ._____ M/F _____/_____/_____ (_____)_____-_____

2 ._____ M/F _____/_____/_____ (_____)_____-_____

3 ._____ M/F _____/_____/_____ (_____)_____-_____

4 ._____ M/F _____/_____/_____ (_____)_____-_____

Parent or Guardian Information

Name of Father_____

Birth date ___/___/_____ SS#_____-_____-_____

Address_____

City_____ State_____ Zip_____

Occupation_____

Employer_____

Home Phone (____) _____-_____

Work Phone (____) _____-_____ Ext.____

Cell Phone (____) _____-_____

Email Address_____

Patient Lives With_____

Name of Mother_____

Birth date ___/___/_____ SS#_____-_____-_____

Address_____

City_____ State_____ Zip_____

Occupation_____

Employer_____

Home Phone (____) _____-_____

Work Phone (____) _____-_____ Ext.____

Cell Phone (____) _____-_____

Email Address_____

Referred By: _____

Billing

Person Responsible for bill_____ SS#: _____

Billing address _____Phone #_____DOB_____

Emergency Contact Information

In an emergency please contact (other than above)_____

Relationship_____ Phone (_____)_____-_____

Signatures

THE UNDERSIGNED AGREES THAT ALL SERVICES ARE RENDERED ON A PAID BASIS ONLY. IF COLLECTION BECOMES NECESSARY, THE UNDERSIGNED SHALL PAY ALL COSTS INCLUDING ATTORNEY'S FEES.

Parent/Guardian Signature _____ Date _____/_____/_____

Parent/Guardian Signature _____ Date _____/_____/_____