

**Cockerell & McIntosh Pediatrics, P. C.**  
**Patient Information Update Form**

*Please Print*

Child's Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex : Male Female

**Where does the child live:**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone No. \_\_\_\_\_ Alternate Phone No. \_\_\_\_\_

**Parent / Legal Guardian Information – (for example Father)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(if unknown, please put "unknown" )

Primary Phone No. \_\_\_\_\_ Alternate Phone No. \_\_\_\_\_

Email address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_

**Parent / Legal Guardian Information– (for example Mother)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(if unknown, please put "unknown" )

Primary Phone No. \_\_\_\_\_ Alternate Phone No. \_\_\_\_\_

Email address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_

**Primary Insurance - A copy of your Insurance card is required**

Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Certificate/ID No. \_\_\_\_\_ Group Name/No. \_\_\_\_\_

**Secondary Insurance - A copy of your Insurance card is required**

Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Certificate/ID No. \_\_\_\_\_ Group Name/No. \_\_\_\_\_

**Additional Insurance - A copy of your Insurance card is required**

Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Address \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Certificate/ID No. \_\_\_\_\_ Group Name/No. \_\_\_\_\_

**Emergency Contact (other than Parents)**

**In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment (including immunizations) for my child/children. I also realize that the person with my child may have access to pertinent protected health information if medically necessary. This authorization will be valid for one year from the date listed below.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

**X** \_\_\_\_\_  
**Signature of Parent/Legal Guardian** **Date**

**Release of Protected Health Information**

**I give permission to release protected health information to:**  
**My daycare/school upon request,**  
**Other healthcare providers for purposes related to your care and treatment, or**  
**We may use and disclose your health information in order to bill and collect payment for services and items you receive.**

**X** \_\_\_\_\_  
**Signature of Parent/Legal Guardian** **Date**

**Sibling Information**

Other child(ren) who receive care from our office:

Sibling's Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex : Male Female  
Sibling's Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex : Male Female  
Sibling's Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex : Male Female  
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