Date:_______________

Pt. ID #:_____________

Salisbury Pediatric Associates

Annual Patient Information Sheet

Patient's Legal Name:_____________________________ ____ ______________________________________

(First Name) (MI) (Last Name)

Address:_________________________________City:___________________________ State:______ ZIp:___________

Patient's Preferred Name:________________________ Date of Birth:__________ SS#:___________________________

Race (check One):

O American Indian/ Alaska Native Sibling(s) Name
O Black/African American DOB
O Native Hawaiian
O Other Pacific Islander
O Asian
O White
O More than 1 race
O Declines to Respond

Ethnicity (check one) :

O Hispanic or Latino O Not Hispanic or Latino

Gender (check one) :

O Male O Female

Sibling(s) Names:	DOB:

Preferred Language:_________________________ Preferred Physician:____________________________

Preferred Notification Method: O Portal message O Phone O Mail

Preferred Email Address:____

Parent Information:

Please note: Legal Documentation will be required for any custody arrangements.

Marital Status: O Married / O Divorced / O Separate / O Single

Who is the Primary Caregiver of the patient? ____

If applicable, who has legal custody? ____

Mother / Legal Guardian	Father / Legal Guardian
Name:____	Name:____
DOB:_______________ Maiden Name:________________	DOB:_______________
Mailing Address:__________________________________	Mailing Address:__________________________________
____ City State Zip	____ City State Zip
Primary Phone #: (_____) _______-___________	Primary Phone #: (_____) _______-___________
Alt. Phone #: (______)________-_____________	Alt. Phone #: (______)________-_____________
Employer:________________________________	Employer:________________________________

EMERGENCY CONTACT (Other than Parent)

Name:____ Relationship:_____________________________________

Primary Phone #: (_____)______-_______________ Alternate Phone #: (_____)-_______________________