



Anshu Dalela, MD

Child 1: _____ **First Name:** _____ **DOB:** _____

Sex: M / F **Gestational age at birth:** _____ **weeks** _____ **days**

Preferred Language: _____

Race (Circle All That Apply): African American American Indian or Native Alaskan Asian
Hawaiian or Pacific Islander White Decline

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Decline

Child 2: Last Name: _____ **First Name:** _____ **DOB:** _____

Sex: M / F **Gestational age at birth:** _____ **weeks** _____ **days**

Preferred Language: _____

Race (Circle All That Apply): African American American Indian or Native Alaskan Asian
Hawaiian or Pacific Islander White Decline

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Decline

Child 3: Last Name: _____ **First Name:** _____ **DOB:** _____

Sex: M / F **Gestational age at birth:** _____ **weeks** _____ **days**

Preferred Language: _____

Race (Circle All That Apply): African American American Indian or Native Alaskan Asian
Hawaiian or Pacific Islander White Decline

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Decline

Child 4: Last Name: _____ **First Name:** _____ **DOB:** _____

Sex: M / F **Gestational age at birth:** _____ **weeks** _____ **days**

Preferred Language: _____

Race (Circle All That Apply): African American American Indian or Native Alaskan Asian
Hawaiian or Pacific Islander White Decline

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Decline

(If you have any more children let us know and we will get another front page)



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Primary Contact:

Child(ren)'s parents are (*Circle One*): Married Divorced Never Married Separated Widow(er) Other

Name: _____ Relationship to Patient: _____

DOB: ___ / ___ / ___ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____

Best number to reach me is (*Circle One*): Work Home Cell

White Cloud Pediatrics may contact me via (Circle One): Work Home Cell Email Portal

White Cloud Pediatrics may leave messages or lab results via (Circle One): Work Home Cell Email Portal

White Cloud Pediatrics may NOT leave messages or lab results via (Circle One): Work Home Cell Email Portal

Lives with patient(s)? Yes / No

(Street)

(City/State/Zip)

Secondary Contact:

Name: _____ Relationship to Patient: _____

DOB: ___ / ___ / ___ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____

Best number to reach me is (*Circle One*): Work Home Cell

White Cloud Pediatrics may contact me via (Circle One): Work Home Cell Email Portal

White Cloud Pediatrics may leave messages or lab results via (Circle One): Work Home Cell Email Portal

White Cloud Pediatrics may NOT leave messages or lab results via (Circle One): Work Home Cell Email Portal

Lives with patient(s)? Yes / No

If they **DO NOT** live with the patient(s), please provide different address:

(Street)

(City/State/Zip)



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Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? Yes / No

If parents are divorced, separated or unmarried, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and ***provide a copy of any legal paperwork*** that supports this restriction. (We ***must*** have this on the patient(s) chart.)

Would you like to sign up for MyKid'sChart (patient portal)?

Yes / No Please provide the best email if so:

Emergency Contacts (other than parents). Name and Relationship:

Name: _____

Relationship to Patient: _____

Phone: _____

Name: _____

Relationship to Patient: _____

Phone: _____

Pharmacy Name: _____

Pharmacy Phone Number and/or Pharmacy Address: _____