Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Phone: (512) 392-1700 Fax: (512) 396-8743

Patient Information

Patient's Name: _____ **DOB:** _____
Gender: ☐ Male ☐ Female
Race: ☐ African-American ☐ White/Hispanic ☐ Asian ☐ Other: _____
Preferred Contact Number: (____) _____

Address: _____
Street City State Zip Code

Name(s) of other siblings and Date of Birth (Put X if not living in the home with Patient)

_____

_____

_____

Parent(s) or Guardian(s) Information

Mother/Guardian Name: _____ Birth Date: _____
Relationship to Patient: _____
Primary Phone: (____) _____ Secondary Phone: (____) _____
Address if different from above:

_____

Employer: _____ Wk#: _____ Social Security # _____

Father/Guardian Name: _____ Birth Date: _____
Relationship to Patient: _____
Primary Phone: (____) _____ Secondary Phone: (____) _____
Address if different from above:

_____

Employer: _____ Wk#: _____ Social Security # _____

The person(s) listed below have my permission to seek medical attention for my child at Corridor Primary Care Pediatrics.

Name	Relationship to Child	Phone Number:
Name	Relationship to child	Phone Number:
Name	Relationship to child	Phone Number:

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.

Date: _____ **Signature** _____

Print Name _____ Referred to our office by: _____