

**THE CARITHERS PEDIATRIC GROUP**  
**PEDIATRICS AND ADOLESCENT MEDICINE**

2121 PARK STREET  
JACKSONVILLE, FL 32204

8750 PERIMETER PARK BLVD  
JACKSONVILLE, FL 32216

Patient's Name \_\_\_\_\_

Last

First

MI

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

Birth Date: \_\_\_\_\_ Sibling's Names: 1) \_\_\_\_\_ 2) \_\_\_\_\_

and DOB 3) \_\_\_\_\_ 4) \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Mother's Cell \_\_\_\_\_ Mother's Work \_\_\_\_\_

Father's Cell \_\_\_\_\_ Father's Work \_\_\_\_\_

Father's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Father's Employer's \_\_\_\_\_ Work Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Work Address \_\_\_\_\_

Where was you child born? \_\_\_\_\_ Obstetrician: \_\_\_\_\_

Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Full Term? \_\_\_\_\_ Vaginal or C-Section? \_\_\_\_\_

Has anyone in the family, including your child, had any of the following? (indicate relationship to child & which side of the family)

Heart Disease \_\_\_\_\_ Birth Defects \_\_\_\_\_

Diabetes \_\_\_\_\_ Seizures/Convulsions \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ Allergies/Hay Fever \_\_\_\_\_

Cancer \_\_\_\_\_ Asthma \_\_\_\_\_

Tuberculosis (TB) \_\_\_\_\_ Alcoholism \_\_\_\_\_

Has your child had chickenpox? (year) \_\_\_\_\_ Allergies/Asthma \_\_\_\_\_

Surgeries, hospitalization or other significant illness \_\_\_\_\_

Who referred our group \_\_\_\_\_

Mother's Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Phone# \_\_\_\_\_

Address where claims should be submitted \_\_\_\_\_

Father's Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Phone# \_\_\_\_\_

Address where claims should be submitted \_\_\_\_\_

Who other than parents is allowed to bring your child to the doctor (please note the relationship to child)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DL# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DL# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DL# \_\_\_\_\_

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

\_\_\_\_\_  
Signature and Date

\_\_\_\_\_  
Signature and Date

Please send a copy of immunizations with this form