McCOMB CHILDREN'S CLINIC

CHART # _____ DATE _____

PREFERRED PROVIDER: ___ARTIGUES ___CHARLES ___HARRELL ___HUBBLE

___ARMSTRONG ___ CRAFT ___TATE

PATIENT'S NAME_____RACE_____

AGE_____SEX_____SOCIAL SECURITY #_____

DATE OF BIRTH_____ PREFERRED PHARMACY_____

STREET ADDRESS OR P.O. BOX _____ COUNTY_____

CITY_____ STATE _____ ZIP _____

PLEASE LIST ANY KNOWN ALLERGIES _____

PREFERRED METHOD OF APPOINTMENT CONFIRMATION (circle one) EMAIL TEXT PHONECALL Phone:

(home)_____ (cell)_____ (work)_____

Email Address _____Would you like a portal invite at this email address: Yes No

FATHER'S NAME (required)_____Social Security # _____ DOB _____

Employed by: _____ Occupation _____DL #_____

Address (if different from child) _____ Phone _____

MOTHER'S NAME _____Social Security # _____ DOB _____

Maiden Name_____ (required)

Employed by: _____ Occupation _____DL #_____

Address (if different from child) _____ Phone _____

NAME OF INSURANCE_____ Policy # _____

Group # _____ Medicaid # _____

OUTSIDE OF THE HOME CONTACTS:

Name _____ Number _____

Name _____ Number _____

PLEASE LIST ALL SIBLINGS WHO ARE ALSO CARED FOR BY McCOMB CHILDREN'S CLINIC DOCTORS:
