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

Preferred email ____

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 info1mation 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:____________________