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**Please select patient(s) Primary Provider: □ BOUDREAUX □ FAUGOT □ RADER**

**Select your preferred way to receive appointment reminders: □ Email □ Text Message □ Voicemail**

|  |  |  |  |
| --- | --- | --- | --- |
| CHILD’S FULL LEGAL NAME: (Print Please) | Date of Birth: | Social Security #: | Sex:  □ Male  □ Female |
| Mailing or Street Address (Where you receive your mail): | Preferred Phone #: | | |
| City, State, & Zip Code: | Secondary Phone #: | | |
| Email Address: □ Mom □ Dad | | | |
| RACE: □ Asian □ Black or African American □ White or Caucasian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ETHNICITY: □ Hispanic/Latino □ Non-Hispanic | PRIMARY LANGUAGE: □ English □ Spanish □ Other: \_\_\_\_\_\_\_\_\_\_\_\_ | | |

**:: PLEASE LIST ADDITIONAL CHILDREN THAT YOU ARE ALSO RESPONSIBELE FOR THAT ARE PATIENT’S HERE ::**

|  |  |  |  |
| --- | --- | --- | --- |
| CHILD’S FULL LEGAL NAME: (Print Please) | Date of Birth: | Social Security #: | Sex:  □ Male  □ Female |
| RACE: □ Asian □ Black or African American □ White or Caucasian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| CHILD’S FULL LEGAL NAME: (Print Please) | Date of Birth: | Social Security #: | Sex:  □ Male  □ Female |
| RACE: □ Asian □ Black or African American □ White or Caucasian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**::: GUARANTOR(S)/LEGAL GUARDIAN(S) INFORMATION:::**

|  |  |  |  |
| --- | --- | --- | --- |
| MOTHER’S NAME: (Print Please) | Date of Birth: | Social Security #: | |
| Mailing or Street Address (If different from above): | Home #: | Work #: | Cell #: |
| MOTHER’S EMPLOYER: | | | |
| FATHER’S NAME: (Print Please) | Date of Birth: | Social Security #: | |
| Mailing or Street Address (If different from above): | Home #: | Work #: | Cell #: |
| FATHER’S EMPLOYER: | | | |

**::: EMERGENCY CONTACT: *(OTHER THAN PARENT(S))* :::**

|  |  |  |  |
| --- | --- | --- | --- |
| NAME: | Relationship to Patient: | Home #: | Cell #: |

**::: INSURANCE ONLY! \*\*PRIMARY Cardholder’s Information :::**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| NAME: | | Relationship to Patent: | | Date of Birth: | | Social Security #: |
| Mailing or Street Address (If different from above) | | Home #: | | Work #: | | Cell #: |
| Primary Insurance: | | | Secondary Insurance (If available): | | | |
| Policy#: | Group#: | | Policy#: | | Group#: | |

**\*\*WE ASK THAT PRESENT A COPY OF YOUR INSURANCE CARD(S) AND ID ON EVERY VISIT.\*\***