



Cepero Pediatrics, P.A.
 3488 Depew Ave.
 Port Charlotte, FL 33952
 Phone 941-764-7923 Fax 941-764-7927

PATIENT DATA SHEET

DATE COMPLETED: _____

PATIENT INFORMATION:

NAME: LAST: _____ FIRST: _____ MI: ___ OTHER NAME KNOWN BY _____
 ___ MALE ___ FEMALE BIRTHDATE: _____ SOCIAL SECURITY #: _____
 LOCAL ADDRESS: STREET/P.O.BOX: _____ APT. # _____
 CITY, STATE: _____ ZIP CODE: _____
 HOME PHONE #: () _____

PRIMARY LANGUAGE SPOKEN IN HOME: _____ **OTHER LANGUAGES SPOKEN** _____

ETHNICITY: ___ Hispanic ___ Non-Hispanic ___ Decline to Answer
RACE: ___ White/Caucasian ___ Black/African American ___ Asian ___ Native Hawaiian or other Pacific Islander
 ___ American Indian or Alaska Native ___ Other ___ Decline to Answer
GENDER IDENTITY: ___ Male ___ Female ___ Genderqueer ___ Female-to-Male(Trans Male) ___ Male-to-Female(Trans Female)
 ___ Other ___ Unknown ___ Decline to answer
SEXUAL ORIENTATION: ___ Straight or Heterosexual ___ Gay, Lesbian or Homosexual ___ Bisexual
 ___ Other ___ Unknown ___ Decline to Answer

PARENT #1 INFORMATION

___ Mother ___ Stepmother ___ Legal Guardian
 Name: _____
 D.O.B: _____ SS#: _____
 Cell phone #: _____
 Work phone #: _____
 Email: _____
 Address (if different from child):
 Street: _____
 City, State: _____
 Zip Code: _____

NAMES OF SIBLINGS

Please list all children in household:

 Please list anyone allowed to bring your child(ren) to office and make decisions for you:

PARENT #2 INFORMATION

___ Father ___ Stepfather ___ Legal Guardian
 Name: _____
 D.O.B.: _____ SS#: _____
 Cell phone #: _____
 Work phone #: _____
 Email: _____
 Address (if different from child):
 Street: _____
 City, State: _____
 Zip Code: _____

EMERGENCY INFORMATION:

Who may we contact in case of emergency that is not the parent(s)?
 Name: _____
 Relationship: _____
 Phone #: _____
 Address: _____

INSURANCE INFORMATION:

List **all** insurances your child is covered by:

May we leave detailed messages on your voicemail?
 YES NO
 May we use text/email for appointment reminders?
 YES NO

 If given the option, based on availability, which provider would you prefer to see at every visit?

Preferred Pharmacy Name: _____
Pharmacy Location: _____
 May we retrieve your child's prescription history? YES NO
 May we update your child's vaccines in the FL Immunization Registry?
 YES NO

Parent Signature: _____ **Date:** _____