OCEANROCK WELLNESS

Charities House
25 Point Finger Road
Paget, DV 04
Bermuda

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Pediatric Information Form

Name: (Last)_____(First)_____(MI)_____

Name you prefer to be called: _____

Birthdate (MM-DD-YYYY): _____ Age: _____ Gender: M F

Parent/Guardian Information:

Parent Name _____

Address: _____Parish_____Postal Code: _____

Home Phone: _____ [] Cellular: _____ [] Work:_____[]

Please check the box [] of your preferred contact number

Parents Employer: _____ Occupation: _____

Work phone No: _____ Ext. _____

Email Address: _____

Insurance Information:

Insured: Y N Insurance Provider: _____ Effective Date: _____

Certificate Number:_____ Group/ Account Number: _____

Insured Person: _____Insured's Birthdate (MM-DD-YYYY) _____

Primary Care Physician:_____

Referring Physician:_____

Contact Persons In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

How did you hear about our Facility?

[ ] Website [ ] Physician [ ] Social Media [ ] Friend/Relative [ ] Advertisement [ ] Other _____

[ ] I have Read and Agree to the Practice Policies

_____ _____

Client's Signature Date