Please complete entire form

Patient & Parent Information

Patient Name: _____ DOB:_____

Mom Name: _____Phone: _____

Dad Name: _____ Phone: _____

Legal Guardian Name: _____ Phone:_____

In foster care: Yes _____ No ____ Adopted: Yes _____ No _____

Insurance: _____ ID #: _____

Address: _____

Email:_____

Preferred Pharmacy/Address: _____

Emergency Contact(Other then Guardian)

Emergency Contact Name 1: _____ Relationship: _____

Emergency Contact Name 2: _____Relationship: _____

Phone 1 :_____ Phone 2 :_____

Policies & Acknowledgments

- **No Recording Policy:** I understand that video, photo, and voice recordings are strictly prohibited inside Mannan Pediatrics to protect patient confidentiality and maintain a respectful clinical environment.
- Mannan Pediatrics follows the immunization guidelines recommended by the **American Academy of Pediatrics (AAP)**. Vaccines are essential to protecting the health of all children in our community.

Signature

I certify that the above information is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ **Date:** _____