**Livermore Pleasanton San Ramon Pediatrics**

Stanford Children's Health

## PATIENT INFORMATION

(over 18 years old)

**YOUR FULL NAME** _____ **DOB** _____ **Gender** M / F / O

Now that you are an adult we need to contact you directly for tests results, visit follow-up calls, appointment reminders etc. Please provide your contact information below:

**Mailing Address:**_____**City:**_____**State:**_____**Zip:**_____

**Primary Phone:**_____ **Cell / Work / Home** (circle one)

**Secondary Phone:**_____ **Cell / Work / Home** (circle one)

**Additional Phone:**_____ **Cell / Work / Home** (circle one)

**Email Address:**_____

How would you like to receive appointment reminders? Text / Email / Phone call /Decline (circle one)

**Emergency Contact**:

Name: _____Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If you would like your parent to have access to medical records, you may fill out an "Authorization for Use and Disclosure of Health Information" a.k.a. "record release" form. Please inquire at the front desk. This may be beneficial if you are going to college and want your parent to be able to pick up immunization records etc. in our office. You can designate what you want them to have access to and the duration of their access on the form.

**Now is a great time to make sure you have a copy of your immunization record especially if you are headed to college.**

**TODAY'S DATE:** _____

**(to be completed yearly)**

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