JoAnne Wise Edoka , M.D., F.A.A.P.

Please Print

Patient Information

<table>
<tr><td colspan="2">Last name First Middle</td><td>Age & Date of birth</td></tr>
<tr><td>Address</td><td>City, State & Zip</td><td>Phone number
Home:
Cell:</td></tr>
<tr><td>Birth Hospital, Birth weight & problems at Birth</td><td>Past Illnesses</td><td>Referred by</td></tr>
<tr><td>History of Family Illnesses</td><td>Allergies</td><td>Pharmacy</td></tr>
<tr><td>List Medications taken</td><td colspan="2">List brothers, sisters & date of birth</td></tr>
<tr><td colspan="3">Race: ___American Indian ___Asian ___Black/African American ___Pacific Islander ___White ___Elect not to disclose
Ethnic Group: ___Hispanic ___Non-Hispanic ___Elect not to disclose
Primary Language: ___English ___Spanish ___Asian ___Other</td></tr>
<tr><td colspan="3">You can elect to access your child's records through the Healow app. Parent's email:</td></tr>
</table>

Responsible Party (Please give your insurance card to the receptionist)

<table>
<tr><td>Father's name:</td><td>Date of Birth</td><td>Phone number</td></tr>
<tr><td>Place of employment</td><td>Occupation</td><td>Work number</td></tr>
<tr><td>Mother's name:</td><td>Date of Birth</td><td>Phone number</td></tr>
<tr><td>Place of employment</td><td>Occupation</td><td>Work number</td></tr>
<tr><td>Insurance Company</td><td>ID number</td><td>Group number</td></tr>
<tr><td colspan="2">Insurance Address</td><td>Phone number</td></tr>
<tr><td>Policy Holder name</td><td>Date of birth</td><td>Employer</td></tr>
</table>

In case of Emergency

Name of relative	Relationship to patient	Phone number

Authorization: I authorize Assignment of Insurance Benefits to JoAnne W. Edoka, MD. I understand I am responsible for payment of services provided but not covered by insurance. I authorize release of Medical Records and other information to requesting insurance companies. I acknowledge responsibility for payment of lab services provided by outside lab services. I acknowledge responsibility for referral procedures and payments to specialist and other healthcare professionals.

_______________________________________ _______________________

Parent/Guardian Signature Date