Joseph T. Sherrel, M.D., FAAP
Pediatric and Adolescent Medicine

Patient Name:_____DOB:_____

MailingAddress_____ Email: _____

City _____State_____ZIP_____

Home #_____ Cell #_____

SSN #_____Best Ph #_____

Fathers Name_____ DOB _____

Employer _____ Wk # _____

Mothers Name_____ DOB _____

Employer _____ Wk #_____

Siblings Name _____Pharmacy_____

Insurance Information : Circle: Private Medicaid

Name of Insurance: _____

Name of Carrier: _____DOB:_____

Referred By: _____

Previous Physician: _____

Name and ph # of nearest relative or friend not living with you. _____

Ethnicity: circle: Non-Hispanic Hispanic

Race: _____ Nationality: _____(ex. American)

Do you give consent for us to recieve patient's medication history from all pharmacies? Circle: Yes No

Do you give consent for us to list patient in the state immunization registry to keep track of your child's immunizations? Circle: Yes No

For you give consent for us to exchange medical information with local hospitals if needed? Circle: Yes No

Do you give consent for us to administer all appropriate and required immunizations? Circle: Yes No

Birth History: Circle: Full Term Premature

Past Medical History:

Drug Allergies _____ Hospitalizations_____

Chronic Medical Problems_____ Surgeries_____

Any other information we should know about your child?

_____