ROXBURY PEDIATRICS

KIMBERLY S. KLAUSNER, M.D. **GUY EFRON, M.D.** **CIGAL SHAHAM, M.D.**

INFORMATION REQUIRED FOR CASE HISTORY FILE

TODAY'S DATE ____________________

PATIENT ____________________ SEX __________ BIRTHDATE ____________________

MOTHER/ PARENT 1 ____________________

HOME ADDRESS ____________________

CITY ____________________ STATE ____________________ ZIP ____________________

HOME PHONE ____________________ CELL PHONE ____________________

FATHER/ PARENT 2 ____________________

- List both addresses if parents living separately -

HOME ADDRESS ____________________

CITY ____________________ STATE ____________________ ZIP ____________________

HOME PHONE ____________________ CELL PHONE ____________________

EMERGENCY CONTACT ____________________ PHONE ____________________

I authorize Drs. Klausner, Efron and Shaham and the Staff of Roxbury Pediatrics to render any medical care necessary to my child.

If I am not available and no other legal guardian is available at the time my child is brought to the office, I authorize in advance that care may be rendered in my absence.

____

Parent Signature Date