



Carteret Clinic for Adolescents and Children

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www.carteretclinic.com

FOR OFFICE USE ONLY
rec'd by _____ / _____
completed by _____ / _____

FAMILY INFORMATION SHEET

CHILD BEING SEEN TODAY (if 18 years old or older, please list your phone #)

Child's Full Name: _____
First Middle Last Suffix Phone #

Child's Mailing Address: _____
Street City / State / Zip

Date of Birth: _____ Social Sec. No.: _____ Gender: Male / Female

Ethnicity: Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** _____

Lives with: Both Natural Parents Mother Father Other (step- or grand parents, etc) _____

Biological Father Name _____ Biological Mother Name _____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon _____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Father/Legal Guardian: _____
FULL Name First Middle Last Suffix

Social Sec. No.: _____

Date of Birth: _____

Mailing Address: _____

Physical Address: _____

City: State: Zip: _____

Phone (H): _____ (W): _____

Mobile: _____ (other) _____

E-Mail: _____

Employer / Occupation: _____

Mother/Legal Guardian: _____
FULL Name First Middle Last

Soc. Sec. No.: _____

Date of Birth: _____

Mailing Address: _____

Physical Address: _____

City: State: Zip: _____

Phone (H): _____ (W): _____

Mobile: _____ (other) _____

E-Mail: _____

Employer / Occupation: _____

Please list any step parents or others involved in this child's care

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please complete this section if there is a court ordered custody agreement. We will need a copy of this documentation.

If parents are separated, divorced or not married, who has custody? FATHER / MOTHER / JOINT / OTHER _____

Are there any **LEGAL** restrictions for either parent that would keep them from consenting to medical treatment for child? YES or NO

(If yes please explain) _____

Emergency Contacts (local and NOT a parent)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Relationship to patient: _____

Print Name: _____ Date: _____