# Pediatric Associates of Youngstown

Khalid Iqbal, M.D. - Riffat P. Iqbal, M.D. - Carrie O. Fadell, M.D.
Khalid Habo M.D. - Susan R. Savich M.D. - Nancy A. Keslar, M.S.N., C.P.N.P.

**Patient's Name** ________________________ **Date of Birth** ____________ **Sex** __________

**Address** ____________________ **City** __________________ **State** ____ **Zip Code** ________

**Phone Numbers: (Home)** ________________ **(Work)** _____________ **(Cell)** ______________

**Child's Social Security Number** _________________ **Delivered by:** _____________________

**Previous doctors:** ____________________________________________________________

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**Person Responsible for Payment** ______________________________________________

**Address (if different from above)** _____________________________________________

**Phone(Cell)** ___________ **Phone : (Home)** ___________________ **(Work)** ______________

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**Parental Status** <u>(CIRCLE ONE)</u> **Married, Divorced, Single, Widowed**

**Father's Name** __________________________ **Mother's Name** _______________________

**Father's Birth Date** ______________________ **Mother's Birth Date** ____________________

**Social Sec. No.** __________________________ **Social Sec. No.** _______________________

**Employer's Name** ________________________ **Employer's Name** ____________________

**Employer's Phone No.** ___________________ **Employer's Phone No.** _________________

**Health Insurance Co.** ____________________ **Health Insurance Co.** __________________

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**In Case of Emergency (Permission to contact)**

**Name of Nearest Friend/Neighbor/Relative** __________________________________________

**Relationship to Patient** ___________________________ **Phone Numbers:** __________________

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**Authorization for Treatment**

**I** _______________________ **Father/Mother/Legal Guardian of** _____________________________
**do hereby authorize Drs. K. Iqbal, R. P. Iqbal, C.O.Fadell, S.R. Savich, K. A. Habo, and N.A.Keslar M.S.N.,C.P.N., to examine the above mentioned child, administer appropriate treatment and immunizations and perform appropriate tests and procedures.**

**Signed** _________________________________ **Date** ____________________________________