Kids Inc.
Helping children develop

Family Information

Client Name _____ M / F DOB _____ Age _____ Soc. Sec.# _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

School _____ Grade _____

Medications _____

Infectious Diseases _____ Allergies _____ Nicotine use _____

Father's name _____ Home Phone _____ Cell _____

Marital Status _____ Soc. Sec.# _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Medications _____

Mother's name _____ Home Phone _____ Cell _____

Marital Status _____ Soc. Sec.# _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Medications _____

Step Parent _____ Soc. Sec. # _____ DOB _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____ Cell _____

Medications _____

1) **Sibling Name** _____ DOB _____ M / F AGE ___ Phone _____

Address _____ School _____ Grade _____

2) **Sibling Name** _____ DOB _____ M / F AGE ___ Phone _____

Address _____ School _____ Grade _____

3) **Sibling Name** _____ DOB _____ M / F AGE ___ Phone _____

Address _____ School _____ Grade _____

Emergency Contact: _____

Phone #**:** _____

Primary care physician: _____

Address: _____

Phone #: _____