RAINBOW PEDIATRICS
MEDICAL RECORDS REQUEST FORM
NEW PATIENTS ONLY

To:_____

Address:_____

Telephone Number:_____ Fax Number:_____

Patients Name:_____ DOB:_____

SSN:_____ Telephone Number:_____

- ☐ Full Medical Record
- ☐ Immunization Record
- ☐ Physical Exams and Growth Charts
- ☐ Specified Item Requested_____

Please drop off, mail or fax requested information to:

Rainbow Pediatrics
153 W. Main Street, Suite 200
New Albany, OH 43054
Phone: 614-939-2200
Fax: 614-939-2201

***Please note we cannot accept CD's with patient information. Thank you.**

_____ _____
Signature of Patient or Guarantor Date

***Please print, complete and forward to your child's previous physician prior to your first appointment in our office. Thank you.**