



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

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.**