PATIENT INFORMATION

Name of Child_____
Last First Middle Initial
Sex M☐ F☐ Birthdate_____Nickname_____
Home Address_____
City_____State_____Zip_____
Mailing Address (if different from home)_____
Home Phone #_____Cell Phone #_____
Language_____Ethnicity_____Race_____

PARENT INFORMATION

Father's/Guardian's Name_____
Address_____
Cell Phone #_____
Email_____
Employer_____
Work Phone #_____
Address_____
Social Security#_____Birthdate_____
Drivers License#_____State_____
Insurance coverage for dependants Yes☐ No☐
Insurance Plan Name_____
Subscriber or ID#_____
Group#_____Phone #_____
Address_____

Mother's/Guardian's Name_____
Address_____
Cell Phone #_____
Email_____
Employer_____
Work Phone #_____
Address_____
Social Security#_____Birthdate_____
Drivers License#_____State_____
Insurance coverage for dependants Yes☐ No☐
Insurance Plan Name_____
Subscriber or ID#_____
Group#_____Phone #_____
Address_____

OTHER CHILDREN IN FAMILY

Name_____Birthdate_____Sex M☐ F☐
Name_____Birthdate_____Sex M☐ F☐
Name_____Birthdate_____Sex M☐ F☐

EMERGENCY CONTACT (other than parent)

Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____

PRIVACY CONSTRAINTS

How may we contact you with personal medical information?
☐ No restrictions. OK to leave messages on voicemail. Best # to call_____
☐ Restricted to parent or guardian ONLY. Non specific messages may be left on voicemail.
Please note any other privacy restrictions_____

RELEASE OF ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that the above information will be held in strict confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

_____ _____
Signature of Parent/Guardian Date