PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Middle Initial
Sex __M __F Age_____ Birthdate_____ Nicknames_____

Family status: Married _____ Divorced _____ Widowed _____ Single _____

Whom may we thank for referring you?_____

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name_____

Employer_____

Social Security #_____
Birthdate_____

Do you have insurance coverage for the minor/child? __Y __N
Plan Name_____

Mother's/Guardian's Name_____

Employer_____

Social Security #_____
Birthdate_____

Do you have insurance coverage for the minor/child? __Y __N
Plan Name_____

EMERGENCY CONTACT

In case of an emergency who should we contact?
Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY NOTICE

Acknowledgement:
I acknowledge that I received the Notice of Privacy Practices.

_____ _____
Patient or personal representative signature Date

If personal representative's signature appears above please describe relation to the patient.

_____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of 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 _____
(name of insurance company)
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 all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether medical or electronic.

Parent/Guardian Signature _____ Date _____