General Information

Patient Name ______________________________
Patient SSN ______________________________
Date of Birth ______________________________
Address ______________________________
City, State, Zip ______________________________
Patient is ☐ a Minor ☐ Single ☐ Married

Today's Date ______________
☐ Male
☐ Female
Home Phone ______________

Responsible Party (Parent)

Name ______________________________
Birthdate ______________________________
Address ☐ Same as patient (skip to next)
Address ______________________________
City, State, Zip ______________________________

Relationship ☐ Parent _______
Home Phone ☐ Same as above
Home Phone ______________
Work Phone ______________
Cell or Pager ______________

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purposes of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefitis (otherwise payable to me) directly to the doctor.

____
Signature and Date

Emergency Contact (May include other parent)

Name ☐ Same as above
Name ______________________________
Birthdate ______________________________
Address ______________________________
City, State, Zip ______________________________

Relationship ☐ Parent _______
Home Phone ☐ Same as above
Home Phone ______________
Work Phone ______________
Cell or Pager ______________

In case of a medical emergency, treatment is approved in my absence.

____
Signature and Date

Insurance Information

Fill out on if Insurance Card is unavailable

Name of Insured ______________________________
SSN ______________________________
Employer ______________________________
Date Employed ______________________________
Address ______________________________
City, State, Zip ______________________________

Relationship ☐ Parent _______
Birthdate ______________
Insurance Company __________
Group Number ______________
Ins Co Address ______________
Deductible / Annual Benefit ___

Additional Insurance

Fill out only if additional insurance

Name of Insured ______________________________
SSN ______________________________
Employer ______________________________
Date Employed ______________________________
Address ______________________________
City, State, Zip ______________________________

Relationship ☐ Parent _______
Birthdate ______________
Insurance Company __________
Group Number ______________
Ins Co Address ______________
Deductible / Annual Benefit ___