#1 Patient Information

Patient's name (#1) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Patient's name (#2) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Patient's name (#3) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Patient's name (#4) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Parent #1's Name ____________________________Date of Birth ____/____/_____

Home address ____

City _______________________________________State _____ Zip ______________________

Home # ________________ Work # _______________ Cell # __________________________

E-mail address: ______________________________ Fax # ______________________________

Which number do you prefer to be called at by our office? __________________________________

Can confidential medical information be left on this number's voicemail? Yes or No

Parent #2's Name ______________________________________ Date of Birth ____/____/_____

Home address (If different from above) ____

City _________________________________ State __________ Zip ________________________

Home # _______________ Work # ______________ Cell # ______________________________

E-mail address: ____________________________________ Fax #_________________________

Which number do you prefer to be called at by our office? ___________________________________

Can confidential medical information be left on this number's voicemail? Yes or No

EMERGENCY INFORMATION

If parents are unavailable, authority is given to contact the following person in case of an emergency:

Name:_______________________________ Relationship:_____________________

Home # _____________________Work # ___________________Cell # ________________________

INSURANCE INFORMATION

Insurance company ____

Group # _______________________ Identification # _______________________________________

Name of primary insured _______________________ Relationship to patient ____________________

Birth Date of primary insured _____ /____ /_____ Social Security # ______-______-______

Name of employer ____________________________________

Whom may we thank for referring you? ____

I authorize the release of any information concerning my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. In lieu of payments which would otherwise be payable to me, I hereby authorize payment directly to the doctor.

Signature ____ Date ____/_____/_____