Please Complete All Sections of This Form

Date: __________________

Patient's Name: ________________________________ Patient's Preferred Name: ________________

Date of Birth: ___________________ Sex: __________ Patient's SSN: ____________________________

Mailing Address: __________________________ City: _____________ State: _____ Zip Code: ________

Preferred Pharmacy: ____

Circle Patient's Race: American Indian • Alaskan Native • Asian • Native Hawaiian • Hispanic
Other South Pacific Islander • African American or Black • White • Other

Circle Patient's Ethnicity: Hispanic or Latino • Not Hispanic or Latino

Person Financially Responsible* for Patient

** If you have private insurance, this should be the parent whose name is listed on the insurance card.*

Name: ___________________________ Relation to Patient: _______________ Date of Birth: _________

SSN: ___________________ Cell Phone # ____________________ Home Phone # __________________

Work Phone # ________________ Which phone number is the best contact number? ________________

Mailing Address: __________________________ City: _____________ State: _____ Zip Code: ________

Email address: ____ Preferred language: ______________

Employer Name: ____ Employer Phone: ________________

Guardian Responsible for Patient

☐ **Same as above (if yes, you do not need to complete this section)**

Name: ___________________________ Relation to Patient: _______________ Date of Birth: _________

Cell Phone # __________________ Home Phone # _________________ Work Phone # ______________

Which phone number is the best contact number? ____

Email address: ____

Authorized Signature _____________________________________ Date ______________________

********* PLEASE FILL OUT THE BACK OF THIS FORM *********

Patient's Name: ______________________________________ Patient's Date of Birth: _________________

Authorization to treat and/or discuss treatment, results, and procedures

This allows others (grandparents, aunts, uncles, etc.) to bring child into office and/or receive results or follow-up instructions

I, _____________________ authorize the following people to consent to evaluation and treatment of above named patient:

Name: _____________________________ Relationship: ______________ Phone:_________________
Name: _____________________________ Relationship: ______________ Phone:_________________
Name: _____________________________ Relationship: ______________ Phone:_________________

Are there any custodial issues that impact authorization of medical care? Yes _____ No _____
If yes, please explain:
____
____

Insurance Information

Primary Insurance Company_____________________________ Policy ID# ______________________

Policyholder's Name ________________________ Pt. /Policyholder Relationship ___________________

Policyholder's Employer ____

Employer's Address ____

Effective Date ______________ Policyholder's SSN ________________ Date of Birth______________

Secondary Insurance Company___________________________ Policy ID# ______________________

Policyholder's Name ________________________ Pt. /Policyholder Relationship ___________________

Policyholder's Employer ____

Employer's Address ____

Effective Date ______________ Policyholder's SSN ________________ Date of Birth______________

Please note that a $15.00 fee will be charged for any after hour or weekend calls that require the assistance of a nurse or physician.

Authorized Signature _____________________________________ Date _____________________