

Patient Information

Last Name _____ First _____ Middle _____ Date of Birth _____ Male / Female

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (____) _____ Referred By: _____

Other Children Information

Last Name _____ First _____ Middle _____ Date of Birth _____ Male / Female

Last Name _____ First _____ Middle _____ Date of Birth _____ Male / Female

Last Name _____ First _____ Middle _____ Date of Birth _____ Male / Female

Last Name _____ First _____ Middle _____ Date of Birth _____ Male / Female

Parent Information

Mother's Name _____ Work Phone(____) _____ Mobile Phone (____) _____

Address, if different _____ Date of Birth _____

Occupation _____ Employer _____

Father's Name _____ Work Phone(____) _____ Mobile Phone (____) _____

Address, if different _____ Date of Birth _____

Occupation _____ Employer _____

Mother's Social Security # _____ Father's Social Security # _____

Mother's Driver's License # _____ Father's Driver's License # _____

Insurance Information

Please present your insurance card to the receptionist so that a copy may be made. Thank you.

Consent for Treatment: I hereby grant permission for the attending physician and staff to examine and provide treatment for my child(ren).

Assignment of Benefits: I hereby assign all medical benefits for office/hospital care to the attending physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I authorize the release of medical records to determine liability for payments and to obtain reimbursement for services rendered.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signed _____ Date _____