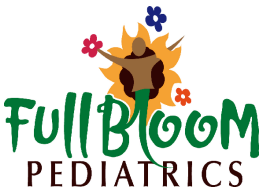

PLEASE FILL OUT COMPLETELY AND RETURN TO RECEPTIONIST

Patient's Name_____DOB_____Sex _____ SS#_____

Preferred Language_____ Race_____ Ethnic Group_____ Tribal Affiliation_____ Decline to Give_____

Mailing Address_____
City State ZIP

Physical Address_____
City State ZIP

Email_____ Preferred Method of Contact: (Phone Call or Text Msg.)

Mother's Name_____DOB_____Home#_____Cell#_____
(First) (Last) (Maiden)

Mother's Employer_____ Phone #_____ SS#_____

Father's Name_____ DOB_____ Home#_____ Cell#_____

Father's Employer_____ Phone #_____ SS#_____

EMERGENCY CONTACTS: (Other than the parents of the patient)

Name_____ Phone #_____ Relationship to Patient_____

Other Emergency Contact: Name_____ Phone #_____ Relationship to Patient_____

Names and Birth Dates of Brothers and Sisters:

1_____DOB_____2_____DOB_____3_____DOB_____

4_____DOB_____5_____DOB_____6_____DOB_____

PRIMARY INSURANCE CARRIER: Name _____ Member#_____ Subscriber Name_____

SECONDARY INSURANCE CARRIER: Name _____Member#_____ Subscriber Name_____

AUTHORIZATION OF BENEFITS AND RELEASE OF INFORMATION

I authorize the release of any medical information necessary for treatment, health care operations and to process my insurance claims. I authorize that medical benefits be paid directly to my physician. I agree that this authorization will cover all medical services until such authorization is revoked by me in writing. I agree that a photocopy of this form may be used in place of the original.

_____

Signature of Responsible Party Date Relationship to Patient

AUTHORIZATION FOR EMERGENCY TREATMENT

In the event that my child should require medical care or treatment and neither parent should be unavailable or out of town, I give my permission for care of my child as deemed necessary.

_____

Signature Date Relationship to Patient

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the release of any and all medical records to the patient's parent/legal guardian. I understand that there will be a nominal fee.

Signature Date Relationship to Patient

UPDATES:

INITIAL_____ DATE_____ INITIAL_____ DATE_____ INITIAL_____ DATE_____ INITIAL_____ DATE_____