

MINOR PATIENT INFORMATION

How did you hear about our practice? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex:  M  F
First M.I. Last

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Minor Social Security # \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Minor living with:  Both Parents  Mother  Father  Other; relationship to minor: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

BILLING INFORMATION:

Name of person responsible for bill: \_\_\_\_\_ SSN # \_\_\_\_\_

Billing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

PRIMARY INSURANCE:

Name of Insurance Co: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth of Policyholder: \_\_\_\_\_

Employer: \_\_\_\_\_

SECONDARY INSURANCE:

Name of Insurance Co: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth of Policyholder: \_\_\_\_\_

Employer: \_\_\_\_\_

FAMILY INFORMATION:

Birth Father: Lives with this child:  Yes  No  Not Involved

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Business # \_\_\_\_\_

Birth Mother: Lives with this child:  Yes  No  Not Involved

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Business # \_\_\_\_\_

Legal Guardian: Lives with this child:  Yes  No

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Business # \_\_\_\_\_

Please List step-parents who live in the home with this child:

Table with 2 columns: Name, Relationship. Includes a blank row for entry.

IMPORTANT: Will anyone other than a biological parent bring than patient to an appointment? If so, please complete Advanced Consent form.

Signature of Parent or Legal Guardian

Date