MINOR PATIENT INFORMATION

How did you hear about our practice? _____

Patient Name: _____ Minor SSN #: _____
First M.I. Last

Date of Birth: _____ Age: _____ Sex: [] M [] F Race: _____ Ethnicity: _____

Minor living with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other Relationship to Minor: _____

Mailing Address: _____ City/State/Zip: _____

Phone: (___) _____ [] Home Email: _____

Phone: (___) _____ [] Cell Preferred Pharmacy: _____
Name Location

Phone: (___) _____ [] Work

Referring Physician: _____ Primary Care Physician: _____

PRIMARY INSURANCE:

Name of Insurance Co: _____

Name of Policyholder: _____

SSN #: _____

Relationship to Patient: _____

Date of Birth of Policyholder: _____

Employer: _____

SECONDARY INSURANCE:

Name of Insurance Co: _____

Name of Policyholder: _____

SSN #: _____

Relationship to Patient: _____

Date of Birth of Policyholder: _____

Employer: _____

FAMILY INFORMATION:

Father: Name: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Business #: _____

Mother: Name: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Business #: _____

Legal Guardian: Lives with this child: ☐ Yes ☐ No
Name: _____ Date of Birth: _____ Relationship: _____

IMPORTANT:
Will anyone other than a parent bring the patient to an appointment? ☐ Yes ☐ No
If yes, please complete Advanced Consent form.

_____ _____
Signature of Parent or Legal Guardian **Date**

*** PLEASE TURN OVER, READ & SIGN***