

CONFIDENTIAL – PATIENT INFORMATION SHEET / CONSENT FORM

Patient _____ Nickname _____

Male Female Birth Date _____ Age _____ Soc. Sec. # _____

Address _____ City _____ Zip Code _____

Child lives with: _____ Home Phone # _____

Guardian/Mother's Name _____ Soc. Sec. # _____

Guardian/Father's Name _____ Soc. Sec. # _____

Responsible Party _____ Relationship _____

Address _____ Phone # _____

Insurance Information

Patient does not have medical insurance

Name of Insured _____

Insured's Birthdate _____ Soc. Sec. # _____

Insured's Employer _____

Employer's Address _____

Insur. I.D.# _____ Group/Policy# _____

Additional Insurance _____

CONSENT FOR TREATMENT: I hereby authorize medical treatment for the above named child. I authorize emergency medical treatment for the above named child, in the event, that he/she is brought into this medical practice by any person other than myself. _____ Initials

AUTHORIZATION AND RELEASE:

I hereby acknowledge that I have received a copy of this medical practice's HIPAA-Notice of Privacy Practices. I further acknowledge that a copy of the current notice is made available/posted in the waiting area, and that I will be offered a copy of any amended notice of Privacy Practices at each appointment. _____ Initials

I hereby authorize and request my insurance company to pay directly to the physician benefits otherwise payable to me. I understand that my medical insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. _____ Initials

Emergency Contact Information:

Name _____ Relationship _____

Address _____ Phone # _____