MINOR PATIENT
Information Form- 2020

Patient _____
first m.i. last

Date _____

• male
Date of Birth ____/_____/_____ Age_____ • female

Address _____

City _____ST____ Zip_____

Phone #_____ _____
home *cell*

PARENTS :

Mother _____ PH_____
• married •s ingle • widowed • divorced

Father _____ PH_____
• married • single • widowed • divorced

Email Address _____

Responsible Party (responsible for bill)
• Mother • Father • Guardian • Foster Parent • Other

Name _____DOB_____

Address _____

City _____ ST_____ Zip_____

Phone_____ _____
home *cell*

SS# _____

Employer_____

Employer Address _____

Employer Phone# _____

Occupation _____

How were you referred to our office?
• Doctor • Hospital • Family • Insurance • Internet • Other

Name _____

Was minor recently seen in hospital by our doctors? •Yes •No

EMERGENCY CONTACT (other than parents)

Name _____ Relationship_____

PH _____
home *cell*

*Address*_____

_____

INSURANCE INFORMATION : (need copy of ins cards)

•PPO •HMO •POS •Cash •CCS/Medi-Cal •Other

Primary Insurance _____

Ins Address _____

City_____ ST___ Zip_____

Subscriber _____ DOB_____

Member ID#_____Grp#_____

Secondary Ins_____

Ins Address _____

Subscriber _____DOB _____

Member ID#_____Grp#_____

CURRENT LIST OF PHYSICIANS

Pediatrician _____Ph _____

Primary Care_____Ph _____

Cardiologist _____Ph_____

Dermatologist_____Ph_____

Other_____Ph_____

_____

_____

PHARMACY Phone # _____

Authorization for Payment/Release of Medical Records

I authorize release of medical records & payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature _____ _____
(relationship to pt)

Photography Consent

I authorize the physician or his assistant to take photographs. The term "photograph: includes all standard & digital photographs, videotapes, etc.. These photographs are the doctor's property and will be a permanent part of the record.

Signature _____Date_____

• *HIPAA Informed Release on File (date)*_____