# **MINOR PATIENT** Information Form- 2021

first       m.i.       last         male       female         Address	Patient		
Date of Birth/ Age female         Address	first	m.i.	last
Address      STZip	_		male
City      STZip	Date of Birth///	Age	female
Phone #	Address		
home       cell         PARENTS :       PH	City	STZip	
PARENTS :       PH	Phone #		
married       single       widowed       divorced         Father      PH		Cell	
married       single       widowed       divorced         Father      PH	Mother	PH	
married single widowed divorced Email Address			
Email Address	Father	PH	
Responsible Party (responsible for bill)         Mother       Father       Guardian       Foster Parent       Other         Name			
Mother       Father       Guardian       Foster Parent       Other         Name      DOB	Email Address		
Name      DOB         Address		-	
Address			
CitySTZip         Phone            SS#         Employer         Employer Address			
Phone       cell         SS#	Address		
home       cell         SS#	City	_ ST Zip	
SS#Employer AddressEmployer AddressEmployer AddressEmployer Phone# 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	Phone		
Employer			
Employer Phone#			
Occupation	Employer Address		
How were you referred to our office?         Doctor       Hospital         Family       Insurance       Internet         Other       Other         Name	Employer Phone#		
Doctor       Hospital       Family       Insurance       Internet       Other         Name	Occupation		
Was minor recently seen in hospital by our doctors? Yes No         EMERGENCY CONTACT (other than parents)         Name         PH         home         cell	•		Other
EMERGENCY CONTACT (other than parents) Name Relationship PH	Name		
Name Relationship PH	Was minor recently seen in hospi	tal by our doctors	? Yes No
PHhome cell	EMERGENCY CONTACT (other	r than parents)	
home cell	Name	Relationsh	ip
home cell	РН		
Address	home		cell
······	Address		
	· · · · · · · · · · · · · · · · · · ·		

Date							
<b>INSURANCE INFORMATION :</b> (need copy of ins cards)							
PPO	HMO	POS	Cash	CCS/Medi-Cal	Other		
Primary	/ Insurar	nce					
Ins Add	ress						
City	City ST Zip						
Subscril	ber	DOB					
Membe	er ID#	Grp#					
Second	ary Ins_						
Ins Add	ress						
Subscril	ber		DOB				
Membe	er 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)\_\_\_\_\_