**MINOR PATIENT**
**Information Form- 2021**

**Patient** _____ **Date** _____
first m.i. last

☐ 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)*_____