PARENT/GUARDIAN INFORMATION

Child's Name ________________________________ Patient # ______________

Parent Name ______________________________
DOB ______________________ Male Female
Address _________________________________
____
City State Zip
Cell phone _______________________________
Home Phone ______________________________
Email ___________________________________
Status: single married divorced other ________
Employer Information:
Employer ________________________________
Occupation _______________________________
Address _________________________________
____
City State Zip

Parent Name ______________________________
DOB ______________________ Male Female
Address _________________________________
____
City State Zip
Cell phone _______________________________
Home Phone ______________________________
Email ___________________________________
Status: single married divorced other ________
Employer Information:
Employer ________________________________
Occupation _______________________________
Address _________________________________
____
City State Zip

INSURANCE INFORMATION

Company Name ___________________________ Insured ID# ____________________________
Include alpha prefix please

Insured's Name ______________________________ Relation ____________________________

Insured's DOB ________________________ Group # ________________________________

_________ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for my balance not paid by my insurance company.

EMERGENCY CONTACT

Contact Name ___________________________ Primary Phone ___________________________

Relation to Patient ______________________ Secondary Phone _________________________

Signature ____ Date _________________