Chart # _____ Date: _____

Child(ren) Information

Name	DOB	Sex	Race	Name	DOB	Sex	Race

Race: Which category best describes your race? AI= American Indian H=Hispanic C=Caucasian AA=African American A=Asian O=Other

Primary Language: _____

Parent or Guardian Information

Check One: ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Guardian

Last Name First Name MI

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ( )Home ( )Work ( ) Cell

Phone: _____ ( )Home ( )Work ( ) Cell

Phone: _____ ( )Home ( )Work ( ) Cell

May we text you office messages to your cell # ( )Yes ( ) No

E-mail Address: _____

Employer: _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

( ) Married ( ) Single ( ) Divorced

( ) Custodial Parent ( ) Guardianship ( ) Joint Custody

Check One: ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Guardian

Last Name First Name MI

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ( )Home ( )Work ( ) Cell

Phone: _____ ( )Home ( )Work ( ) Cell

Phone: _____ ( )Home ( )Work ( ) Cell

May we text you office messages to your cell # ( )Yes ( ) No

E-mail Address: _____

Employer: _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

( ) Married ( ) Single ( ) Divorced

( ) Custodial Parent ( ) Guardianship ( ) Joint Custody

Other Parent or Guardian

Check One: ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Guardian

Last Name First Name MI

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ( )Home ( )Work ( ) Cell

Phone: _____ ( )Home ( )Work ( ) Cell

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Is other Parent or Guardian permitted by law to have access to the child's medical records? Yes or No.

PLEASE SEE BACK FOR ADDITIONAL INFORMATION

If other Parent or Guardian has no legal right to the child's information, you must provide written documentation from the Courts stating such facts.

Primary Insurance

( ) Family Policy ( ) Individual ( ) Other Effective Date: _____

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Is this a high deductible plan ? (HSA) Yes ____ or No ____

Secondary Insurance

( ) Family Policy ( ) Individual ( ) Other Effective Date: _____

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Is this a high deductible plan ? (HSA) Yes ____ or No ____

Emergency Contact (other than parent)

Name: _____ Relationship: _____

Address: _____ Phone # _____

City _____ State _____ Zip _____

Pharmacy Information:

Pharmacy Name: _____ Number: _____ Fax: _____

We will automatically file your insurance claim if we have a copy of your insurance card and if the Assignment of Benefits is signed below. This information must be updated annually and when your insurance changes. You are responsible for what insurance does not pay within 30 days of the insurance receipt. Any cost incurred with the collection of your account is your responsibility. If you have any questions concerning your account or the filing of your insurance, please contact the bookkeeping office Monday-Thursday 8:30 am to 4:00 pm @ 452-6707.

Release of Information and Assignment Benefit

I authorize the release of medical information necessary to process my medical claims. I authorize payment from my insurance company to be made directly to the facility. I understand that I am responsible for and agree to pay any and all expenses not covered by my insurance or any that are not paid by the insurance company in a reasonable and timely manner. My signature also serves as consent for medical treatment.

SIGNATURE	DATE	RELATIONSHIP (If other than patient)