PATIENT INFORMATION- CHILDREN ONLY

PATIENT NAME: _____ **M / F**

DATE OF BIRTH: _____

PRIMARY PHONE: _____

CELL PHONE: _____

SSN: _____

ADDRESS: _____

_____

City **State** **Zip code**

WHO IS ACCOMPANYING THE PATIENT TODAY?

NAME: _____

RELATION: _____

LEGAL GUARDIAN **Y / N**

REFERRED BY: _____

ALTERNATE PHONE: _____

EMAIL: _____

PARENT/GAURDIAN INFORMATION:

MOTHER____GUARDIAN_____

NAME: _____

ADDRESS: _____

_____

PHONE: _____

WORK PHONE: _____

DATE OF BIRTH: _____

SSN: _____

EMPLOYER: _____

FATHER____GUARDIAN_____

NAME: _____

ADDRESS: _____

_____

PHONE: _____

WORK PHONE: _____

DATE OF BIRTH: _____

SSN: _____

EMPLOYER: _____

PRIMARY INSURANCE

Insurance Name: _____

Policy Number: _____

Subscriber Name: _____

Subscriber SSN: _____

SECONDARY INSURANCE

_____

_____

_____

_____

EMERGENCY CONTACT INFORMATION (NOT LIVING WITH PATIENT)

NAME: _____ PHONE: _____

Name of person(s) other than parents allowed to bring child in for appointments when parent is unavailable: Name/relation

_____ _____ _____

PREFERRED CONTACT NUMBER (to be reminded of appointments): _____

May we contact you by email? Y / N

I hereby authorize the physician and employees to render routine medical care. The duration of this consent is indefinite and continues until revoked in writing.

I request that payment of authorized insurance company benefits be made on my behalf to Tracy C Crnic, MD, PA for any service furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information provided and have completed the above answers. I certify that the information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the given information.

Signature (Parent if minor) _____ Date _____

Information Reviewed and Confirmed as Correct by Patient/Parent

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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Signature: _____ Date: _____