PATIENT INFORMATION FORM

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Patient Name:_____ Nickname:_____
DOB:_____
Cell Phone:_____ Email (for appointment reminder):_____
Sex: Male or Female (circle) Gender: _____ Pronouns: _____
Name of school patient attends:_____
Whom may we thank for referring you?:_____
Does your child have siblings?:_____ If so, names & ages:_____

Responsible Party

Name of person responsible for this patient:_____Relationship to patient:_____
Address :_____City: _____
State:_____Zip:_____ Home phone:_____ Cell Phone:_____
Birth Date:_____ Social Security:_____
Email Address:_____Marital Status:_____

Insurance Information

Name of Insured:_____ Relationship to patient:_____
Birthdate:_____Social Security:_____Date Employed:_____
Insured Address:(if different from above) _____City:_____ State:____ Zip:_____
Name of employer:_____Occupation:_____Work Phone:_____
Insurance Co:_____Tel #:_____Group#:_____Policy/ID#:_____
Amount of your Deductible:_____Max Annual Benefit:_____

In my absence, I give permission to:_____to accompany my child and consent for any needed treatment.

You agree that by checking the Electronic Signature such action will constitute your electric signature having the same legal force and effect as a hand written signature

Signature of patient (or parent, if minor) _____