# Patient Information

Thank you for choosing our office. To serve you properly, we need the following information. **Please print.** All information will be confidential.

Date: _____ Patient Name: _____ Male / Female

Birthdate: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip code: _____ Parents Name: _____

Email Address: _____

Whom may we thank for referring you: _____

**********

**Parent or Responsible Person for child**

Parent or Responsible person name: _____

Address: _____ Home Phone: _____

Driver's License #_____ Birthdate: _____ SSN_____

Employer: _____ Work Phone: _____

**********

**Insurance Information**

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Employer: _____

Insurance Company: _____ ID#: _____

Group #: _____ Address of Insurance: _____

Phone # of Insurance: _____

**********

I authorize the release of any information concerning my child's health care, advice and treatment provided for evaluating and administering claims for insurance benefits. I also here by authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____

Signature of Parent Date