CHART#_____

MINOR/STUDENT PATIENT INFORMATION SHEET

PATIENT **Date: _____**

First Name: _____ MI _____ Last Name: _____

Sex: M / F Date of Birth: _____ Home Telephone: _____

Address: _____ City: _____ State: _____Zip: _____

Referred By: _____ Telephone: _____

Ethnicity: Latino/Hispanic / Non-Latino/Hispanic

Race: Caucasian / Black or African American / Asian / Native American or Alaskan Native / Hawaii Native or Pacific Islander/ Multiracial //// Refuse to Answer

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Please Include ALL Parents' Information:

Parent Name: _____ SSN#: _____ DOB: _____

Home Tele: _____ Cell: _____

Address: _____City: _____State: _____ Zip: _____

Employer: _____ Employer Telephone Number: _____

Mother / Father / Other: _____

Parent Name: _____ SSN#: _____ DOB: _____

Home Tele: _____ Cell: _____

Address: _____City: _____State: _____ Zip: _____

Employer: _____ Employer Telephone Number: _____

Mother / Father / Other: _____

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Primary Insurance Company: _____ ID#: _____

Who Carries this Insurance?: _____
Indicate any info if different than a parent:_____

Secondary Insurance Company: _____ ID#: _____

Who Carries this Insurance?: _____
Indicate any info if different than a parent:_____

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Fees and Payments:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. We submit claims to your insurance as a COURTESY. It is **your** responsibility to pay any deductible/co-insurance or any outstanding balance not paid for by your insurance company.
**My signature on file is my authorization for the release of information necessary to process my claim(s).
** If this account is turned over to collections, I agree to pay all collection costs, attorney fees, and or court costs.
I HEREBY AUTHORIZE PAYMENT directly to the physician named of the insurance benefits otherwise payable to me.

SIGNATURE: _____ **DATE: _____**