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 **<u>your</u>** 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:** _______________