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MINOR PATIENT INFORMATION FORM

Patient Information

Name (First, Middle, Last) _____

Birthdate _____ Social Security _____ Male _____ Female _____

Address _____ City _____ Zip _____

Day Phone _____ Evening Phone _____ E-mail _____

Emergency Contact _____ Phone _____

Primary or Referring Physician _____ Phone _____

Mother's Information (please select one)

Mother

Stepmother

Guardian

Name (First, Middle, Last) _____

Birthdate _____ Social Security _____

Address _____ City _____ Zip _____

Day Phone _____ Evening Phone _____ E-mail _____

Employer _____ Occupation _____

Address _____ City _____ Zip _____

Does mother have legal custody of child (circle one)? Yes No

Marital status (circle one)? Single Married Partnered Divorced Separated Divorced Widowed

Father's Information (please select one)

Father

Stepfather

Guardian

Name (First, Middle, Last) _____

Birthdate _____ Social Security _____

Address _____ City _____ Zip _____

Day Phone _____ Evening Phone _____ E-mail _____

Employer _____ Occupation _____

Address _____ City _____ Zip _____

Does father have legal custody of child (circle one)? Yes No

Marital status (circle one)? Single Married Partnered Divorced Separated Divorced Widowed

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

Person Completing this Form (If personal information is included on other side, please enter name only)

Name (First, Middle, Last) _____

Birthdate _____ Social Security _____

Address _____ City _____ Zip _____

Day Phone _____ Evening Phone _____ E-mail _____

Employer _____ Occupation _____

Address _____ City _____ Zip _____

Does you have legal custody of child (circle one)? Yes No

Insurance Information

Primary Insurance

Subscriber Name (First, Middle, Last) _____

Birthdate _____ Social Security _____ Relationship to Patient _____

Insurance Company _____

Subscriber ID No. _____ Group No. _____

Secondary Insurance

Subscriber Name (First, Middle, Last) _____

Birthdate _____ Social Security _____ Relationship to Patient _____

Insurance Company _____

Subscriber ID No. _____ Group No. _____

Consent for Treatment & Assignment of Benefits

Allergy Associates is hereby authorized to perform all necessary and advisable medical procedures for diagnosis and treatment of this child. I understand that Allergy Associates will inform me of all medical procedures and treatments prior to commencement, except in case of emergency.

I assign to and approve direct payment to Allergy Associates of any insurance benefits otherwise payable for this child's treatment until this assignment is revoked by me in writing. I hereby authorize said assignee to release information necessary to secure payment. I request that payment of authorized insurance benefits be made on my behalf to Allergy Associates for any services furnished to this child.

I fully understand that I am financially responsible to Allergy Associates for charges not covered by this assignment to my insurance carrier(s).

Signature _____ Date _____

Account Number _____ Verified By _____ Entry Date _____