



UNIVERSITY PEDIATRIC ASSOCIATION

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Middle Name Nickname

Sex: Male Female Date of Birth _____ Social Security # _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone # _____ Father's Mobile # _____ Mother's Mobile # _____

BILLING INFORMATION

_____ Father/Guardian Name _____ Mother/Guardian Name (Maiden Name)

Address (if different from patient's) _____ Address (if different from patient's) _____

Home Phone # _____ Home Phone # _____

Work Phone # _____ Work Phone # _____

Employer _____ Employer _____

Date of Birth _____ Drivers Lic. # _____ Date of Birth _____ Drivers Lic. # _____

Social Security # _____ Social Security # _____

EMERGENCY CONTACTS

In the event of an emergency, whom should we contact? (Someone other than parent/guardian)

Name _____ Relationship to patient _____ Phone # _____

Name _____ Relationship to patient _____ Phone # _____

RELEASE AND ASSIGNMENT

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent/guardian before any and/or all necessary medical services can be started and accomplished by the physicians at University Pediatric Association.

I authorize the release of any medical or other information required in the processing of claims. I authorize my insurance benefits to be paid directly to the health care provider.

My signature as parent/guardian affixed below authorizes the rendering of medical services. This consent shall remain in full force and effect until cancelled by either party. I understand that I am financially responsible for all charges incurred as a result of medical services rendered.

The following persons may, in my absence, present my child for medical treatment: _____

Signature of Parent/Guardian

Date