

CHILD PATIENT INFORMATION

NAME _____ AGE _____ SOCIAL SECURITY # _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME # _____ WORK # _____ CELL # _____
 DATE OF BIRTH _____ () MALE () FEMALE

PARENT / GUARDIAN INFORMATION

MOTHER'S NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 EMPLOYER _____ HOME # _____ WORK # _____ CELL # _____
 EMAIL _____ MAY WE LEAVE A CONFIDENTIAL MESSAGE/TESTS RESULTS WITH MOTHER ON HER:
 HOME PHONE CELL PHONE (✓ CHECK ALL THAT APPLY)

FATHER'S NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 EMPLOYER _____ HOME # _____ WORK # _____ CELL # _____
 EMAIL _____ MAY WE LEAVE A CONFIDENTIAL MESSAGE/TESTS RESULTS WITH FATHER ON HIS:
 HOME PHONE CELL PHONE (✓ CHECK ALL THAT APPLY)

LEGAL GUARDIAN NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____
 (IF NOT PARENTS)
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 EMPLOYER _____ HOME # _____ WORK # _____ CELL # _____
 EMAIL _____ MAY WE LEAVE A CONFIDENTIAL MESSAGE/TESTS RESULTS WITH THIS PERSON ON HIS/HER:
 HOME PHONE CELL PHONE (✓ CHECK ALL THAT APPLY)

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP TO PATIENT _____
 HOME # _____ WORK # _____ CELL # _____

INSURANCE INFORMATION

PRIMARY INSURANCE:		GROUP #	POLICY # / I.D. #:
ADDRESS:		PHONE #:	EFFECTIVE DATE:
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:	
DATE OF BIRTH:	SEX:	SOCIAL SEC. #:	SUBSCRIBER EMPLOYER INFO:
SECONDARY INSURANCE:		GROUP #:	POLICY #:
ADDRESS:		PHONE #:	
POLICY HOLDER'S NAME:		SOCIAL SEC. #:	

PARENT/GUARDIAN SIGNATURE _____

DATE _____

CONTINUE ON BACK →

**MEDICAL TREATMENT AUTHORIZATION FOR MINORS
AND
AUTHORIZATION RELEASE FOR TESTS RESULTS/CONFIDENTIAL INFORMATION**

I authorize the following people to bring my child to Dr. Bostock's office for medical treatment in my absence and you may leave confidential messages/tests results on the numbers indicated below.

NAME	RELATIONSHIP	HOME #	CELL #
NAME	RELATIONSHIP	HOME #	CELL #
NAME	RELATIONSHIP	HOME#	CELL #

IF CHILD IS OF LEGAL DRIVING AGE MAY THEY BRING THEMSELVES IN FOR TREATMENT? YES NO

PLEASE LIST OTHER HOUSEHOLD MEMBERS

NAME	AGE	NAME	AGE	NAME	AGE
NAME	AGE	NAME	AGE	NAME	AGE

AUTHORIZATION

I voluntarily consent to medical treatment for myself to the Providers at the office of Dr. William K. Bostock. I give consent to Dr. William Bostock or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I understand that I have a right to have provided to me and review Dr. William Bostock's Notice of Privacy Practices before signing this document. The Notice of Privacy Practices is also posted for review in the reception area. This notice describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the practice of health care operations of the practice.

Dr. William Bostock reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notion of privacy practices by calling the office and requesting that a revised copy be sent to me or asking for one at the time of my next appointment.

I hereby authorize payment of medical benefits to Dr. William Bostock for any services rendered. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of service. I understand that I am responsible for the bill should my insurance company not pay.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL

Parent/ Legal Guardian Signature

Date