PATIENT INFORMATION

Date _____

CHILDREN'S FULL NAME (list all children)	SEX	NICKNAME	BIRTHDATE	SOC. SER. #

PREFERRED PHARMACY: _____

Parent/Guardian: _____ Relationship _____
FIRST MI LAST

Address _____
STREET CITY STATE ZIP

Home Phone_____ Work Phone _____Cell_____

E-Mail _____

Birth date _____Soc. Sec # _____ Employer_____

Insurance Co. _____Policy Number _____Group # _____

Parent/Guardian:_____ Relationship _____
FIRST MI LAST

Address _____
STREET CITY STATE ZIP

Home Phone_____ Work Phone_____ Cell _____

E-Mail _____

Birth date _____ Soc Sec # _____ Employer_____

Married ❑ Single ❑ Divorced ❑
Who Has Legal Custody: Mother ❑ Father ❑ Grandparents ❑ Other ❑ _____

WHO CAN WE CONTACT IN CASE OF AN EMERGENCY (RELATIVE OR FRIEND, NOT LIVING IN YOUR HOUSEHOLD)

Name: _____ Phone _____ Cell _____

Address: _____
CITY STATE ZIP

How did you find out about us _____

In my absence _____ is authorized to sign for medical care for my children

BY SIGNING I AUTHORIZE DR. BREEDEN TO PROVIDE MEDICAL TREATMENT FOR MY CHILDREN AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BILLS INCURRED FOR THIS MEDICAL TREATMENT. I AUTHORIZE THE RELEASE OF INFORMATION BY PHONE, FAX, MAIL OR INTERNET AS REQUESTED BY MY INSURANCE COMPANY FOR THE PROCESSING OF INSURANCE CLAIMS.

SIGNATURE _____ DATE _____