Marsh Dermatology

MINOR PATIENT REGISTRATION FORM

PATIENT INFORMATION Today's Date: _____/_____/_____
Month Day Year

Child's Name:____
First Middle Last

Date of Birth: _____/_____/_____ Child's Gender: Male____ / Female____
Month Day Year

Referring Physician_________________________________City________________________

Primary Physician__________________________________City_________________________

Home Address:____
Street # Street Name Apt#

____
City State Zip

Legal Guardian or
Parent Name:______________________________ Parent Date of Birth: _____/_____/_____
Month Day Year

Home Phone: ( ) _____________Work Phone: ( ) _____________Cell Phone: ( ) _______________

Which is the best number to reach you? Home____ Work____ Cell____

Parent's Social Security Number: _____ - _____ - ______ Child's Social Security Number:: _____ -_____ - ______

In case of Emergency, who should be notified? ________________________Phone____________________

Please add your preferred pharmacy: ______________________________City ________________________

INSURANCE INFORMATION (Please present Insurance card and Photo ID at time of check-in)

Primary Ins. Co.__________________________ **Secondary** Ins Co. _________________________________

Name of Insured__________________________ Name of Insured___________________________________

Insured's ID/Policy #_____________________ Insured's ID/Policy #_______________________________

Group # _______________________________ Group # ____

Relationship of Patient to the Insured _____________ Relationship of Patient to the Insured _______________

Do we have your permission to:

- Treat your child if they are unaccompanied by a parent? YES / NO
- Leave a message on your answering machine at home? YES / NO
- Leave a message at your place of employment? YES / NO
- Discuss the child's medical condition with any member of your household? YES / NO
  - If Yes, whom: _______________________ Relationship to patient: ________________

In order to establish optimal relations with our patients and avoid misunderstandings regarding out payment policies, please note: IT IS THE POLICY OF THIS OFFICE THAT THE ADULT PRESENTING THE CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF "THE PATIENT PORTION" AT THE TIME OF SERVICE. Your signature below indicates that you understand and accept this policy.

____ _______/______/______
Signature of Parent / Legal Guardian Date