



# Calvary Medical Clinic

*"Where Your Healing Begins"*

## CHILD INFORMATION FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent's Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent / Guardian's Email Address: \_\_\_\_\_

Parent's Name: Mother \_\_\_\_\_ Father \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Parent's Occupation: \_\_\_\_\_ Parent's Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Parent's Occupation: \_\_\_\_\_ Parent's Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred By:  Phone Book  Newspaper  Hospital  Another Physician  Friend/Relative Other: \_\_\_\_\_

### WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR ACCOUNT WITH?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR MEDICAL RECORDS WITH?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*\*IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY? \*\*** Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Ph #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*\*WHO IS RESPONSIBLE FOR PAYMENT \*\*** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Group # Or Plan Name: \_\_\_\_\_ Subscriber Or ID #: \_\_\_\_\_

For continuity of care, I give consent for Calvary Medical Clinic to obtain my prescription history. YES NO

**\*Payment is expected at the time services are rendered unless previous arrangements have been made. As a courtesy our office will file your insurance claims for the physician's fees in the event of hospitalization.\*** I also authorize Calvary Medical Clinic to release any information necessary in the course of my treatment required by the insurance company covering these procedures and I permit a copy of this authorization to be used in the place of the original. I understand that I am responsible for all amounts not covered by insurance. I have received a notice of this organization's privacy practices.

Patient or Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Name(printed): \_\_\_\_\_