PATIENT INFORMATION FORM ⎕**ALLERGY ALERT:**
PLEASE COMPLETE ENTIRE FORM.

PATIENT: (THIS SECTION REFERS TO PATIENT ONLY)

Client's Name:				
Address:				**Birth Date:**
City:	**State:**	**Zip:**	**School:**	
Home Phone (including area code):			**Grade:**	
Parent/Caregiver cell phone:			**Parent/Caregiver cell phone:**	
Emergency Contact (EC):			**EC Relationship:**	**EC Phone #:**

FILL IN IF PATIENT IS A MINOR

Parent/Guardian Name:	**Date of Birth:**	**Parent/Guardian Name:**	**Date of Birth:**
Address (if different from client):		**Address (if different from client):**	
Email:		**Email:**	

INSURANCE

Primary Insurance Co.:		**Secondary Insurance Co.:**	
Subscriber's Name:		**Subscriber's Date of Birth:**	
Employer		**Employer's Phone:**	
Employer Address:		**Plan:**	
Policy #:	**Group #:**	**Policy #:**	**Group #:**
Copay Amount:		**Copay Amount:**	

OTHER INFORMATION

ALLERGIES Food: □ No □ Yes If Yes, list: **Medication: □ No □ Yes If Yes, list:**
Current Medications:
Significant Medical History (Illness/Surgeries):
Diagnosis/Primary Care Physician:

I authorize my physician, health care provider, and their representatives to release any information relating to an illness, injury, diagnosis, care or treatment to my insurance company, health plan, Medicaid, or third party payor or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records

and medical information, including: psychiatric, psychological, nervous/mental, substance abuse (e.g. alcohol and drug abuse) and HIV and HIV-related information. I understand that the reason for furnishing such information may include the following: for use in medical, financial or provider auditing, or such other auditing as may be legally required, for utilization and/or quality of care review and assessment and for determining available health benefits and coverage.

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Patient's signature/Parent's/Legal Guardian's signature/Date