GILMAN FAMILY PRACTICE (minor child Age 0-12)

PATIENT INFORMATION:

Last Name_____ First Name:_____ Middle Initial:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Birthdate:_____ Soc Sec#:_____ Phone#:_____

Gender: _____Male _____Female _____Other/Specify_____

Race: ____White/Caucasian _____Black/African American _____Native Hawaiian/Other Pacific Islander _____Asian _____American Indian/Alaskan Native _____Refused

Ethnicity: _____ Hispanic or Latino _____Non Hispanic or Latino _____Other _____Refused

Mother/Guardian Name:_____ Father/Guardian Name:_____

Pharmacy Name:_____ Location:_____

Emergency Contact:_____ Relationship:_____ Phone#_____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Ins Co Name:_____	**Ins Co Name:_____**
ID#_____GRP#_____	**ID#_____GRP#_____**
Subscriber Name: _____	**Subscriber Name:_____**
Birthdate:_____Relationship:_____	**Birthdate:_____Relationship:_____**
Employer:_____	**Employer:_____**

ADVANCED CONSENT TO TREAT MINORS AND RELEASE OF BENEFITS INFORMATION

I authorize my insurance benefits to be paid directly to Gilman Family Practice for services provided by them. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time for service for all copays, deductibles, and noncovered services. I give Gilman Family Practice permission to release my minor child's private health information required for treatment, referrals, payment, claims, and healthcare operations.

ALL COPAYS ARE DUE AT TIME OF SERVICE

I authorize and consent to routine and emergency medical treatment for _____ when deemed necessary by qualified medical personnel. **(Minor's Name)**

Do we have permission to leave a DETAILED message of the minor's medical information on your voicemail?

_____YES _____NO If YES, which phone#?_____

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

CONTINUE ON REVERSE SIDE