

**WEST HILLS DERMATOLOGY GROUP**  
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**Minor Patient Registration Form**

Minor's Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_  
                    First                                  Middle                                  Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Female  Male

Race:             American Indian or Alaska Native    Asian             Native Hawaiian or Other  
Pacific Islander  
                     Black or African American                       Hispanic or Latino                       White

Home Address:

\_\_\_\_\_  
Street#    Street Name    Apt#

\_\_\_\_\_  
City    State    Zip

Phone # (day): \_\_\_\_\_ Phone # (evenings): \_\_\_\_\_

Legal Guardian or Parent Name:

\_\_\_\_\_  
                    First                                  Middle                                  Last

Phone # (day): \_\_\_\_\_ Phone # (evenings): \_\_\_\_\_

**Payment Policy**

The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

**Insurance Information:**

Primary Insurance Carrier: \_\_\_\_\_

Name of Insured (Guarantor): \_\_\_\_\_ Guarantor D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Name of Insured (Guarantor): \_\_\_\_\_ Guarantor D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

**May we leave medical information about the minor on your answering machine or cell phone?**  YES  NO

**May we e-mail personal medical information about the minor to you?**  YES  NO

E-mail address: \_\_\_\_\_

**Do you give our office permission to discuss medical information about your minor with family members?**  YES  NO If yes, please provide their name and phone number below.

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

Phone # (day): (\_\_\_\_\_) \_\_\_\_\_ Phone # (evening): (\_\_\_\_\_) \_\_\_\_\_

**Emergency Contact Information:**

In case of Emergency, whom should we notify? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent / Legal Guardian Signature Date

***Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.***