



**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.***