

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.