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.