PATIENT CENTERED CARE, PLL-C
CHILD INFORMATION FORM

Patient Name: _____ Sex: M___ F____
First Middle Last
Patient's Preferred Name: _____ Birthdate: _____

Address: _____

City: _____State:_____Zip:_____

Home Phone #:_____Cell Phone #:_____

School: _____Grade:_____Age:_____

MOTHER/GUARDIAN INFORMATION:
Name: _____SS#_____

Employer: _____Work Phone #:_____

FATHER/GUARDIAN INFORMATION:
Name: _____SS#_____

Employer: _____Work Phone #:_____

Person financially responsible for payment (Circle one): Mother Father Other

Address (if different than above):_____

City: _____ State: _____Zip Code: _____

Phone number: _____ Email Address_____

Insurance (please circle): YES NO

Name of Insurance Company: _____

Policy Holder's Name: _____Group #:_____

I request and authorize the provider to examine, clean and provide treatment on for my child. I shall be responsible for any incidental expenses including all collection costs and reasonable attorney fees.

Signature of Parent/Guardian: