

PATIENT INFORMATION SHEET FOR PATIENTS OVER THE AGE OF 18 YEARS

THIS FORM MUST BE FILLED OUT LEGIBLY AND IN FULL

**PATIENT NAME**: DOB: Sex: \_\_\_\_\_\_\_ SS#: - -

RACE (OPTIONAL): American Indian/Alaskan Native Asian Black/African-American Hawaiian/Pacific Islander White Other Decline/Refuse to Answer/Unknown

ADDRESS: Email:

 STREET CITY ZIP

PHONE NUMBER: ALT. PHONE NUMBER:

MOTHER’S MAIDEN NAME: PREFERRED PHARMACY:

NAME STREET/TOWN

EMERGENCY CONTACT:

 NAME PHONE NUMBER RELATIONSHIP TO PATIENT

EMERGENCY CONTACT:

 NAME PHONE NUMBER RELATIONSHIP TO PATIENT

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will not be permitted to have access to my medical records or information about my care without my specific written permission.

I wish to grant my parent(s)/guardian(s) access to my healthcare providers, appointment and/or medical information as follows:

***(Printed below are the name(s) and relationship of those who may act on my behalf)***

Name: Relationship:

Name: Relationship:

*Please select and initial one of the following options:*

 I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or staff member at Pediatric Associates of Watertown to schedule appointments, discuss my healthcare and access my medical records. THEY HAVE NO RESTRICTIONS

 I do not grant any access to my parent(s)/guardian(s). No medical record or information may be accessed or discussed. No appointment information may be released.

This consent will be valid for one year from the date signed. I understand that I may withdraw or change my consent at any time by submitting a new written consent form indicating the changes in access.

Patient Name:

Patient Signature: Date:

Witness:

Witness Signature: Date:

**BILLING INFORMATION**

Primary Insurance Company: Policy ID#: Group #:

Policy Holder’s Name: DOB: SS#: - -

Employer: Address same as patient? Y / N

If no:

 STREET CITY ZIP

Secondary Insurance Company: Policy ID#: Group #:

Policy Holder’s Name: DOB: SS#: - -

Employer: Address same as patient? Y/N If no:

 STREET CITY ZIP

**Please designate who you would prefer as your Primary Care Provider:**

OFFICE USE ONLY

Date rec’d\_\_\_\_\_\_\_\_\_\_\_\_\_

Date entered\_\_\_\_\_\_\_\_\_\_\_\_ Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_