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PATIENT/FAMILY CONTACT FORM

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 _____
Address _____
City, State, Zip _____
Email Address _____
Consent to text Consent to email

Phone _____
Secondary Phone _____
Relationship _____

Parent/Guardian #2 _____
Address _____
City, State, Zip _____
Email Address _____
Consent to text Consent to email

Phone _____
Secondary Phone _____
Relationship _____

If applicable, please list step-parent name(s): _____

If you have documentation about custody and medical decision making, please provide this to the front desk.

Preferred Pharmacy _____
(Name and Address)

Financial Responsibility

Person responsible for bills _____

SSN _____ DOB _____

The above parent/guardian information is applicable to all children listed below:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

PERMISSION TO TREAT A MINOR CHILD WITHOUT A PARENT/GUARDIAN PRESENT

In the event that I, the parent/guardian, cannot accompany my child(ren) to Montgomery Pediatrics, I give permission to the following persons to consent to any necessary medical care including vaccines and other forms of treatment for the above minor child(ren) on the advice of any physician at Montgomery Pediatrics. The person(s) named below must bring your child's health insurance card (if not on file) and copay with them to the appointment.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This consent will remain in effect until revoked by parent/guardian.

Parent/Guardian (please print) _____ Relationship _____

Parent/Guardian Signature _____ Date _____