

PATIENT CONTACT INFORMATION UPDATE

Today's Date: _____

Children in household:

Name of Child: _____	Date of Birth: _____
Name of Child: _____	Date of Birth: _____
Name of Child: _____	Date of Birth: _____
Name of Child: _____	Date of Birth: _____

Address where the above children reside: _____
(If addresses differ, please use another form)

Parent/ Legal Guardian #1: _____ **Phone:** _____
Relationship: (circle) Mother Father Other: _____

Parent/ Legal Guardian #2: _____ **Phone:** _____
Relationship: (circle) Mother Father Other: _____

Please list any step-parents or other relatives involved in child's care who may contact us to schedule appointments or accompany the child to visits: _____

***Please note:** *Our staff will not get involved in any custody issues. If a legal guardian designates a step-parent or other person to bring the child to our practice for treatment, we will treat the child.*

Telephone Contact Information

Mobile Contact Phone Number (For confirmations - text or voice) () _____ - _____

To whom does it belong? Mother Father Other _____

Alternate Phone Number (Must be authorized to receive information) () _____ - _____

Mobile? Landline? To whom does it belong? Mother Father Other _____

*The incidental release of information could occur during routine and necessary communications between staff and other contacts listed in the patient's file if a phone call regarding patient care is necessary. This information could be related to appointment scheduling / cancellations / confirmations, billing issues, or a return call regarding a medical issue. **Please note that both biological / legal parents are given access to patient records and information REGARDLESS of custody unless a legal order exists that restricts contact with or about the child.***

Name of person completing this form: _____ **Relationship:** _____

Signature of parent / guardian: _____