# CHILD/ADOLESCENT PATIENT INFORMATION SHEET

_____. _____. _____.
Patient's name (First/Middle/Last) Date of Birth Social Security #

_____. _____. ___-___-____.
Mother's Name (First/Middle/Last) Date of Birth Social Security #

_____. (____) ____-____.
Mother's Home Address: (Street) Mother's Home Phone #

_____.
Mother's Home Address: (City/State/Zip) E-mail:

_____. _____.
Mother's Employer Occupation

_____. (____) ____-____.
Employer's Address Mother's Business #

_____. _____. ___-___-____.
Father's Name (First/Middle/Last) Date of Birth Social Security #

_____. (____) ____-____
Father's Home Address: (Street) Father's Home Phone #

_____
Father's Home Address: (City/State/Zip) E-mail:

_____. _____
Father's Employer Occupation

_____. (____) ____-____
Employer's Address Father's Business #

Parent's Marital Status : ( )Married, ( )Divorced, ( )Widow/Widower, ( )Other
If divorced, is either parent remarried? ( )Mother, ( )Father

_____. _____. _____.
Child's School (Address & Phone #) Grade Primary Teacher

_____.
Pharmacy: Name_____Fax_____Phone_____

REFERRAL SOURCE (Please give address & phone #, if known):

_____.

***RESPECTFULLY, A 24 HOUR CANCELLATION NOTICE IS <u>REQUIRED:</u>***
***OTHERWISE, YOU WILL BE CHARGED***
***There is a $35 charge per RX for replacing a prescription between appointment times during business hours and a $50 charge per RX during evening, holiday and weekend hours.***

<u>PERMISSION TO PROVIDE SERVICES/RESPONSIBILITY FOR PAYMENT:</u> I hereby grant permission to H. William Martin, M.D. to provide services to the minor child listed above and do hereby accept full and complete responsibility for all debts and obligations incurred during the course of said patient's treatment.

_____. _____. _____.
Signature of Responsible Party Signature of Parent Date