Welcome To Our Office! (Minor) Today's Date:

Name:_____
First Middle Last
Birth Date: _____Age: _____ **Child's** SSN: _____ SEX: M F
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ Child's Cell Phone: ( ) _____
Primary Care Physician: _____
Referring Physician_____

Legal Guardian/Father's Name: _____
Relationship to Patient: _____
Birth Date: _____ Age:_____ SSN: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____
Cell Phone: ( ) _____
Work Phone: ( ) _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

Legal Guardian/Mother's Name: _____
Relationship to Patient: _____
Birth Date: _____ Age:_____ SSN: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____
Cell Phone: ( ) _____
Work Phone: ( ) _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Work Phone: ( ) _____

List Physicians you give permission for Grand Island Dermatology to release your medical information to: _____

Do we have your permission to?
Contact you or leave a message on your home or cell phone regarding your health care issues?

Yes No

Insurance Information (Minor) Today's Date

Patient's Name: _____
First Middle Last

Primary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____Date of Birth: _____
Group Number: _____Policy ID Number: _____
Employer: _____
Social Security Number of the Insured: _____

Secondary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____Date of Birth: _____
Group Number: _____Policy ID Number: _____
Employer: _____
Social Security Number of the Insured: _____

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ☐ Cash ☐ Check ☐ Visa/MC/Discover

Signature of Patient /Responsible Party:_____ Date: _____

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical and surgical benefits to Jennifer Alberts, MD/Grand Island Dermatology.

Signed: _____ Date: _____
(Patient /responsible party)

I authorize medical treatment of my minor child. This includes any medical or minor surgical procedures furnished by Grand Island Dermatology.

_____ _____
Parent/Legal Guardian's Signature **Date**

Many times parents/guardians find themselves unable to accompany their teens or young adults to their appointments. Please sign below if you will be sending your child to his/her appointment alone. You will be allowing the clinic to treat your child without your presence.
I hereby grant Grand Island Dermatology permission to treat my child when they arrive at the office unaccompanied for one year from the date signed below.

_____ _____
Parent/Legal Guardian's Signature **Date**