CHILD HEALTH ASSOCIATES, P.C.

I _____ (name of parent/guardian) give permission for Child Health Associates, P.C. to provide all necessary medical care for my child/children

PLEASE LIST ALL CHILD/CHILDREN **LEGAL NAMES**:

Sex at birth (M F) FIRST_____ MI__ LAST_____DOB ___/___/_____ Preferred Name/Pronoun _____

Sex at birth (M F) FIRST_____ MI__ LAST_____DOB ___/___/_____ Preferred Name/Pronoun _____

Sex at birth (M F) FIRST_____ MI__ LAST_____DOB ___/___/_____ Preferred Name/Pronoun _____

Sex at birth (M F) FIRST_____ MI__ LAST_____DOB ___/___/_____ Preferred Name/Pronoun _____

Sex at birth (M F) FIRST_____ MI__ LAST_____DOB ___/___/_____ Preferred Name/Pronoun _____

PARENT AND/OR GUARDIAN (PRIMARY CONTACT)

FIRST_____MI____ LAST_____ DOB ____/_____/____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

CELL PHONE_____BUSINESS PHONE_____HOME PHONE_____

OCCUPATION_____ EMPLOYER_____

EMAIL ADDRESS_____ PREFERRED CONTACT # CELL - HOME - BUSINESS (cirlcle one)

PARENT AND/ OR GUARDIAN (SECONDARY CONTACT)

FIRST_____MI____ LAST_____ DOB ____/_____/____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

CELL PHONE_____BUSINESS PHONE_____HOME PHONE_____

OCCUPATION_____ EMPLOYER_____

EMAIL ADDRESS_____ PREFERRED CONTACT # CELL - HOME - BUSINESS (cirlcle one)

WITH WHOM DOES/DO THE CHILDREN RESIDE_____

PREFERRED PHARMACY NAME & LOCATION_____

****BILLING ADDRESS (IF DIFFERENT FROM ABOVE)****

NAME_____ADDRESS_____

CITY_____STATE_____ ZIP_____ PHONE NUMBER _____

HOW DID YOU HEAR ABOUT OUR PRACTICE:_____

EMERGENCY MEDICAL RELEASE/CONSENT

I, _____ give my permission for (list below) to seek medical care for my child/children through office visits or telephone advice. **(Someone other than the parent or guardian)**

NAME_____**RELATIONSHIP**_____ **PHONE**_____

NAME_____**RELATIONSHIP**_____ **PHONE**_____

DATE_____ SIGNATURE_____

NP 2023