Patient Contact Information
For Patients 18 years and older

Date:_____

Once you reach your eighteenth birthday, you are legally an adult in regards to medical decisions and medical care, even if you are covered by a parent's insurance plan. Without your written consent, our office cannot discuss any aspects of your care with your parents. You will have to initiate all contact with us if there are questions or concerns. If you would like your health information shared with parents, guardians, or other organizations, you must give us authorization at the bottom of this form.

Patient's Name: _____ Nickname: _____
Last, First, Middle

Date of Birth: _____ Gender: _____ Primary Language: _____

Address:_____ Email: _____

City _____ St _____ Zip_____ Ph#_____

☐ Student ☐ Employed School or Place of Employment _____

Ethnicity: _____ Race: _____

Social Security No:_____ Who should receive billing statements? _____

Insurance Policy Holder's Name_____DOB:_____Relationship to patient:_____

Insurance Co:_____Member ID_____Group No:_____Effective Date:_____

Name of pharmacy:_____Phone:_____Address:_____

Consent to release patient information

☐ I do not allow you to release my medical records to anyone but me.

OR

☐ I give the following adult(s) permission to receive my medical records. Medical records include physicians' notes, X-rays, lab results, immunizations, prescriptions, and medical reports from other physicians. Note that your medical records could include results of STD, HIV, AIDS and pregnancy testing, substance abuse records, and mental health records.

Contact 1: _____ Relationship: _____

Email: _____ Phone:_____

Contact 2: _____ Relationship: _____

Email: _____ Phone:_____

☐ I will share only my insurance information with:

Contact 1:
_____ Relationship: _____

You are financially responsible for any and all payments: copay, coinsurance or deductible that your insurance deems as your responsibility even though you may still be covered under your parent's insurance.

My signature below indicates I am the patient listed above, that I have provided accurate information to the best of my knowledge.

Patient signature_____ Date_____