



### MINOR CHILD INFORMATION

Client's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Employed By: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Employed By: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Address (if different from Child's) \_\_\_\_\_

### CONSENT TO TREAT BY GUARDIAN

Name of Guardian: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Children in Family (list names, ages & occupations): \_\_\_\_\_  
\_\_\_\_\_  
List anyone else living in household: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Medical Insurance Company: \_\_\_\_\_  
Membership Number: \_\_\_\_\_ Medical Coverage Code: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_

### Insurance Authorization - Please Read and Sign

I hereby authorize Dr. Jeanne R. Hogan to furnish information to insurance carriers or government agencies concerning my child's illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. A copy of this signature is as valid as the original.

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

NOTE: All patients are expected to pay their portion of the bill within 30 days upon receipt of first statement. Cash, check, money orders are all acceptable. If any problems are anticipated in paying the bill on time, please discuss the problem now.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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