SILVER CROSS
MEDICAL GROUP
The way you *should* be treated.

Pediatric Patient Data Information

Child's Name: _____ Birth Date ____ / ____ / ____

Sex: ☐ Male ☐ Female

Child's Race: _____ Child's Ethnicity: _____

Child Resides with: ☐ Both parents ☐ Father ☐ Mother ☐ Other

Mothers Name: _____ Birth Date ____ / ____ / ____

Mothers Address: _____ City _____

State _____ Zip _____ Home Phone_____Other Phone _____

Fathers Name: _____ Birth Date ____ / ____ / ____

Fathers Address: _____ City _____

State _____ Zip _____ Home Phone_____Other Phone _____

Legal Guardian if applicable: _____ **(Legal documentation required.)**

Address_____ City _____

State _____ Zip _____ Home Phone_____Other Phone _____

Emergency Contact: _____ Relationship _____ Phone _____

Pharmacy (name, location, phone #) _____

Mail Order Pharmacy (if applicable) _____

Contact for Results:

I authorize Silver Cross Medical Group to contact for results:

Parents Only ☐

☐ Home ☐ Cell

OK to leave a message on answering machine? ☐ Yes ☐ No

Other ☐ Name _____ Relationship _____

Authorization to Treat: Parents/Legal Guardians please read and sign agreement:

- I hereby give my consent for the providers at Silver Cross Medical Group to evaluate and treat the patient listed above
- I hereby authorize my insurance benefits to pay directly to Silver Cross Medical Group, realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carrier

Signature: _____ Date _____