Pediatric Offices of Drs. Greg Savel, Karen Kelly, Kathryn Boreman and Kimberly Odom

PATIENT INFORMATION

DATE ____________ CHART # ____________

How did you hear about our practice? ____________

If any child(ren) listed below are over the age of 18 years old, they must sign this form consenting for the parent/guardian to receive ANY protected health information.

CHILD'S FULL NAME ____________ ____________ ____________ / / ______
First Middle Last Date of birth Sex

Allergies? ____________ Race ______ **18 & over Signature** ____________

Contact # ( )

CHILD'S FULL NAME ____________ ____________ ____________ / / ______
First Middle Last Date of birth Sex

Allergies? ____________ Race ______ **18 & over Signature** ____________

Contact # ( )

CHILD'S FULL NAME ____________ ____________ ____________ / / ______
First Middle Last Date of birth Sex

Allergies? ____________ Race ______ **18 & over Signature** ____________

Contact # ( )

CHILD'S FULL NAME ____________ ____________ ____________ / / ______
First Middle Last Date of birth Sex

Allergies? ____________ Race ______ **18 & over Signature** ____________

Contact # ( )

PARENT/GUARDIAN #1

Name ____________
First MI Last

Birthdate / / SS # - -

Employer ____________

Occupation ____________

Home # ( )

Cell # ( )

Work # ( )

Home Mailing Address ____________

City State Zip

email ____________

PARENT/GUARDIAN #2

Name ____________
First MI Last

Birthdate / / SS # - -

Employer ____________

Occupation ____________

Home # ( )

Cell # ( )

Work # ( )

Home Mailing Address ____________

City State Zip

email ____________

If there are any family members or others who may be notified in an emergency or bring your child/children in for treatment and receive protected healthcare information (including HIV testing, drug & alcohol testing & psychotherapy treatment) please list below.

Name ____________ Phone # ____________ Relationship ____________

Name ____________ Phone # ____________ Relationship ____________