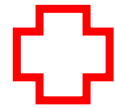


# Calvary Medical Clinic



"Where Your Healing Begins"

## CHILD INFORMATION FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Sex:  Male  Female SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Parent's Cell Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Alternate Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Parent / Guardian's Email Address: \_\_\_\_\_  
Parent's Name: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mother's Employer: \_\_\_\_\_  
Parent's Occupation: \_\_\_\_\_ Parent's Work Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Father's Employer: \_\_\_\_\_  
Parent's Occupation: \_\_\_\_\_ Parent's Work Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Referred By:  Phone Book  Newspaper  Hospital  Another Physician  Friend/Relative  
Other: \_\_\_\_\_

### WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR ACCOUNT WITH?

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

### WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR MEDICAL RECORDS WITH?

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**\*\*IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY? \*\*** Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Ph #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Work Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Alternate Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**\*\*WHO IS RESPONSIBLE FOR PAYMENT \*\*** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Cardholder Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Group # Or Plan Name: \_\_\_\_\_ Subscriber Or ID #: \_\_\_\_\_

For continuity of care, I give consent for Calvary Medical Clinic to obtain my prescription history. YES NO

**\* Payment is expected at the time services are rendered unless previous arrangements have been made. As a courtesy our office will file your insurance claims for the physician's fees in the event of hospitalization. \* I also authorize Calvary Medical Clinic to release any information necessary in the course of my treatment required by the insurance company covering these procedures and I permit a copy of this authorization to be used in the place of the original. I understand that I am responsible for all amounts not covered by insurance. I have received a notice of this organization's privacy practices.**

Patient or Parent/Guardian Signature: \_\_\_\_\_  
Parent/Guardian Name (*printed*): \_\_\_\_\_

Cleveland Clinics  
108 S. William Barnett Ave  
Cleveland TX 77327  
281-592-9775  
Fax: 281-432-0548

Livingston Clinic  
309 Hwy. 59 S. Loop  
Livingston, TX 77351  
936-327-1055  
Fax: 936-329-8800

Humble Clinic  
8484 Will Clayton Pkwy  
Humble, TX 77338  
832-995-5200  
Fax: 281-995-5201