Patient Contact Information
For Patients 18 years and older

Date:_____

Once you are eighteen, you are legally responsible for your 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: _____ Preferred Name: _____
Last *First* *MI*

Date of Birth: _____ Gender: _____ Ph#_____

Address:_____ Email: _____

City _____ St _____ Zip_____ **O** Student **O** Employed

School or Place of Employment _____

Who is the insurance holder? **O** Mother **O** Father **O** Other:_____

Who is responsible for paying any balance on your account?

O Self Cell:_____Email: _____

O Mother Cell:_____Email: _____

O Father Cell:_____Email: _____

O Other: Name: _____ Cell:_____Email: _____

Name of pharmacy:_____Phone:_____Address:_____

Your consent to release your patient health information to another adult

Read carefully, then select ONE option:

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

OR

O 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:_____

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

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_____