RAYMOND ALDRIDGE, M.D., P.C.
MINOR PATIENT INFORMATION

Patient			
Mailing Address **City** **State** **Zip**			**Phone** Home Work Cell or Alternate
Date of birth	**Age**	**Gender**	**Social Security #**
Parents		**Mother's B.D.** **Father's B.D.**	**Mother's SS #** **Father's SS #**
Mother's Employer			
Mother's Employer Address			**Mother's Employer Phone**
Father's Employer			
Father's Employer Address			**Father's Employer Phone**

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**

Primary physician

Referring physician

Pharmacy

HIPPA INFORMATION
Please list any other person that we can release your information to:
PLEASE CIRCLE RELATIONSHIP

	Relationship:	Grandmother/ Grandfather	Aunt/Uncle	Friend
	Relationship:	Grandmother/Grandfather	Aunt/Uncle	Friend
	Relationship:	Grandmother/Grandfather	Aunt/Uncle	Friend

CONSENT TO TREAT
I give permission to the physician and whomever he may designate as his assistant(s) to administer such treatment as is necessary, and to perform any medical care, procedure or testing that is considered therapeutically necessary based on findings during my examination or treatment.

CONSENT FOR HIPAA, RELEASE OF INFORMATION, AND PAYMENT
I hereby authorize Dr. Raymond Aldridge and/or his Associates to release any protected health information pertaining to the examination, treatment, history, prescribed medications, and medical expenses of myself to any physician, hospital, Medicare, Medicaid, Tricare, Insurance Company and all other agencies deemed necessary. I understand that I have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. I also authorize payment of medical benefits to Dr. Raymond Aldridge for services rendered. I understand that I am financially responsible for any co-pays, co-insurance, or deductibles require by my insurance company. I also understand that I am financially responsible for charges that are not covered by my insurance company.

Signature of patient or authorized person ______________________________

Date ________________