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