

Waterboro Village Pediatrics, LLC, PA

Patient Update Form — MINOR

SECTION 1: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Sex: _____ Preferred Pronouns: _____ Language: _____

Race: _____ Ethnicity: _____

Primary Phone: _____ Email: _____
(Please circle: Cellphone / Landline) (Would you like to sign up for our Patient Portal? Please Circle: Yes / No)

Mailing Address: _____
(PO Box or Street, City/Town, State, Zip Code)

Home Address: _____
(Street, City/Town, State, Zip Code)

Pharmacy: _____
(Pharmacy Name & City/Location)

SECTION 2: NAME OF PARENT, STEPPARENT, FOSTER PARENT, OR LEGAL GUARDIAN WHO RECEIVES THE BILL

Name: _____ Relationship to Child: _____

Date of Birth: _____ Marital Status: _____ Sex: _____

Primary Phone: _____ Secondary Phone: _____
(Please circle: Cellphone / Landline) (Please circle: Cellphone / Landline)

Mailing Address: _____
(PO Box or Street, City/Town, State, Zip Code)

Employer Name: _____ Work Phone: _____ Ext: _____

Employer Address: _____
(Street, City/Town, State, Zip Code)

Other Parent's Name: _____ Primary Phone: _____
(Please circle: Cellphone / Landline)

SECTION 3: INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Waterboro Village Pediatrics

Medical Care Permission Form

Dear Parent(s) / Legal Guardian(s),

In cases of emergency or because of unforeseen circumstances, parent(s) or guardian(s) cannot always be present at office visits for illnesses or well-child exams. It is important to realize that medical decisions must still be made regarding the care of your child in these situations. Therefore, Waterboro Village Pediatrics is requesting that you provide us with a list of additional persons to whom you would delegate the authority to make medical decisions for your child in your absence. Medical decisions may include, but are not limited to, diagnostic tests and procedures, administration of medications, and required and/or recommended vaccinations. It is your responsibility to make your intentions clear to whomever you delegate authority to in regards to your child's medical care.

I hereby give permission to the following persons to authorize medical care for my child at the time of visit or to be contacted in the event of an emergency:

Contact Name	Relationship to Patient	Phone Number

If for some reason none of the persons listed above can bring your child in and you need to have a non-listed person bring the child, please send with that person a signed note that authorizes them to seek medical treatment for and make medical decisions regarding the care of your child. Please include any specific information and/or requests that would be helpful for Waterboro Village Pediatrics staff in providing the best care for your child. If no signed authorization note is provided, we will allow for a one-time-only verbal authorization from you for the non-listed person to accompany your child, after which that person must be added to the medical permission form or they will not be allowed to bring the child to future visits.

If you plan to send an older child in alone for a visit without an accompanying authorized person, please let us know ahead of time and relay any specific information and/or requests regarding your child's care. In these instances, you must be available by phone during the visit in case we need to contact you.

This consent is valid for one year and will need to be completed again upon expiration. By signing this form, I acknowledge that I have read, understand, and agree to the terms of this permission form.

Name of Patient (please print): _____

Signature of Parent / Legal Guardian: _____

Date: _____