GILMAN FAMILY PRACTICE (minor patient Age 12 to 18 yrs.)

TODAY'S DATE:			DO NOT LIST AN EMAIL ADDRESS FOR MINORS	
☐ BRYCE H. GILMAN, DO ☐ KRISTINA A. STEWART, PAC ☐ LAURIE DIMLER, ARNP				
Patient Name: Last		First	M.I.	Gender: M F
Mailing Address:	Apt:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:		ext.
Which Phone Number Do You Authorize our Staff to Use to leave Voicemails Containing Private Health Information?				
Patient Date of Birth:		Age:	Patient SS#(optional):	

PATIENT RACE: ☐ CAUCASIAN ☐ AFRICAN AM ☐ ASIAN ☐ NATIVE AM ☐ OTHER_____ ☐ MORE THAN ONE ☐ REFUSE

PATIENT ETHNICITY: ☐ LATINO HISPANIC ☐ OTHER ☐ REFUSED

Patient's marital status ☐ married ☐ single ☐ widow ☐ divorced ☐ separated

Name of Patient's Spouse (if applicable):

Emergency Contact:	Relationship to Patient:	Phone Number:

MINOR OR SPECIAL NEEDS PATIENT'S INFORMATION

Minor's Mother or Guardian Name: (Only necessary if patient is a Minor)	Minor's Father or Guardian Name: (Only necessary if patient is a Minor)
Guarantor Name: Guarantor Phone #: (Person responsible for paying the bill - Guarantor is required if the patient is a Minor)	Address: (If different than patient's address.)

☐ EMPLOYED ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED (PATIENT EMPLOYMENT IF NOT A MINOR)
(USE GUARANTOR'S EMPLOYMENT INFORMATION FOR MINOR PATIENT OR SPECIAL NEEDS PATIENT)

Name of Employer:	Occupation:

PREFERRED PHARMACY NAME AND LOCATION

Pharmacy Name:	Pharmacy Location:

INSURANCE INFORMATION – WE MUST HAVE A COPY OF YOUR INSURANCE CARD AND PROOF OF IDENTIFICATION

Primary Insurance Co:	Secondary Insurance Co:
Group #:	Group #:
Policy ID# or Claim#	Policy ID# or Claim#
IS THE PATIENT THE SUBSCRIBER:YES ☐ NO ☐ IF NO THEN:	IS THE PATIENT THE SUBSCRIBER: YES ☐ NO ☐ IF NO THEN:
Subscriber's Name:	*Subscriber's Name:*
Subscriber's Employer:	*Subscriber's Employer:*
Subscriber's Date of Birth: / /	*Subscriber's Date of Birth:* / /
Subscriber's Relationship to Patient:	*Subscriber's Relationship to Patient:*

Release of Benefits Information

I authorize my insurance benefits to be paid directly to Drs. Gilman, Curalli and Gilman for services provided by them. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment is due at time of service.)

Patient/Authorized Signature:	Date: \ \
Insurance Subscriber's Signature:	Date: \ \

GILMAN FAMILY PRACTICE (minor patient Age 12 to 18 yrs.)

Complete the reverse side……..

Our notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you.

Today's Date:_____

Patient Name:_____Date Of Birth:_____Age:_____

PARENT/GUARDIAN – PLEASE COMPLETE THIS SECTION.

☐ I give Dr. Bryce H. Gilman and his staff permission to use and disclose all (without exclusion) protected health information about the minor patient for treatment, payment and health care operations.

PARENT/GUARDIAN ADVANCED CONSENT TO TREAT MINORS

I, _____, the parent or legal guardian of my child, _____, authorize and consent to routine and emergency medical treatment for _____ when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me or when _____ no longer requires my consent for treatment.

Parent/Guardian
Signature_____Date_____

(MINOR PATIENT AGE 12+) PLEASE COMPLETE THIS SECTION

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION TO A FAMILY MEMBER, CAREGIVER OR OTHER PERSON.

☐ I authorize Dr. Bryce H. Gilman and his staff to release my Protected Health Information to: Must be completed by the patient.

Name:	Relationship:
Name:	Relationship:

We will contact the minor patient before disclosing sensitive Protected Health Information that includes any of the following:

• Contraception • HIV (Aids) • Sexually Transmitted Diseases • Mental Disorders
• Drug/Alcohol Use

Additional Exclusions (if any)_____

Minor-Patient Phone Number_____(required)

Patient Signature_____Date_____
(Minor Patients 12 and above must sign this form or we cannot honor consent.)

This document will automatically expire after 1 year.

*If we cannot reach you for medical or billing reasons, we may verify your personal contact information by calling your emergency contact. Also, the emergency contact may be called if you have a medical emergency in our office.