**Mark G. Gilchrist, MD, LLC**

# PEDIATRICS

**Child's Name**_____**Date of Birth**_____**Sex**____

**Address**_____
Number and street City State Zip

**Race**: (circle all that apply) American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander Black or African American White Hispanic Other Race Refused to Report

**Ethnicity**: (circle one) Hispanic or Latin Not Hispanic or Latin Refused to Report

**Parent (or Guardian)**_____Address_____
DOB_____ (if different than child's)

**Parent (or Guardian)**_____Address_____
DOB_____ (if different than child's)

**Siblings** _____

**Best Number to Reach You:**

**1)**_____**(home/cell/work) (Mom/Dad/Patient) Please circle**

**2)**_____**(home/cell/work) (Mom/Dad/Patient) Please circle**

**3)**_____**(home/cell/work) (Mom/Dad/Patient) Please circle**

**Emergency Contact**_____
(other than child's parents) Name Address Phone

**Preferred Pharmacy**_____
Name Address

Patient agrees to release of prescription history from pharmacy. Yes_____No_____

## Consent for Treatment of a Minor

This is to authorize and consent to any necessary or routine medical or surgical treatment including examination, injection, immunizations and/or diagnostic procedures, including X-ray or lab tests***. I understand that only myself or those listed below will have the authority to authorize treatment.***

| Name | Relationship to Patient |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment could be refused or delayed. I understand that efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

## Assignment of Benefits

I authorize direct payment of surgical/medical benefits to Mark G. Gilchrist, MD, LLC for services rendered by him or any health care provider working in this office. I understand, and agree that I am financially responsible for any balance not covered by my insurance and agree to pay the balance.

## Authorization to Leave Messages

I agree to allow your office to leave messages on my answering machine/voice mail in reference to items that assist in carrying out the care and treatment of my child including appointment reminders, insurance items and normal lab and X-ray results. YES_____ NO_____
This authorization will remain in effect unless so designated, in writing, until the child is no longer a patient of this practice.

**Parent/Guardian Signature**_____**Name**_____