LEON & KRONBERG PEDIATRIC CENTER

2017

Information & Consent to Treat

All information must be fully completed by the parent or guardian each year.

Please PRINT CLEARLY in the spaces provided. Be sure to sign and date this document.

	Mother: (First, and Surname)	Father: (First, and Surname)
Name:		
Date of Birth:		
Social Sec. #:		
Drivers Lic #:		
Home Address:		
E-mail Address:		
Home Phone:	( )	( )
Cell Phone:	( )	( )
Employer:		
Employer Address:		
Employer Phone #:		

Emergency Contact:	Phone #: ( )	Relationship:

Subscriber Name: (Person responsible)		Date of Birth:
	Social Sec. #:	Phone #:
Insurance Company:		Subscriber Phone #:
Insurance Company Address:		Insurance Company Phone #:
Member or Policy#:	Group #:	

	Child(ren)'s Legal Name: (First, and Surname)	Sex	Date of Birth:
1.			
2.			
3.			
4.			

✓ I have received Leon & Kronberg Pediatric Center's practice policies. I understand and accept them.

✓ I certify that the above information is accurate, complete and truthful.

I HEREBY AUTHORIZE LEON & KRONBERG PEDIATRIC CENTER AND THEIR STAFF TO RENDER MEDICAL TREATMENT TO MY CHILD OR CHILDREN AS THEY DEEM NECESSARY.

Signature: _____ Date: _____

Print Name: _____