MAHONEY
DERMATOLOGY SPECIALISTS, P.A.

Minor Patient Registration Form

Please fill out in entirety

Minor's Name: _____
First Middle Last

Prefers to be called: _____ Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female

Parents Employer: _____ Employer's Phone #: _____

Home Address: _____
Street# Street Name Apt#

_____
City State Zip

Phone # (Home): (_____)_____ Phone # (Cell): (_____)_____

Pharmacy Name: _____ Pharmacy Phone #: (_____)_____
(This will enable us to send prescriptions directly to your pharmacy)

Pediatrician:_____ Referring Physician:_____

Payment Policy: The Adult/Guardian who brings in the child, will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

Insurance Information:

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor D.O.B.: ____/____/____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor D.O.B.: ____/____/____

May we leave medical information about the minor on your answering machine or cell phone? ☐YES ☐ NO
Preferred contact: ☐ Home Phone ☐ Cell Phone

May we e-mail personal medical information about the minor to you? ☐YES ☐ NO

E-mail address: _____ (Parent email)

Do you give our office permission to discuss medical information about your minor with family members other than patient's parent/guardian? ☐ YES ☐ NO

Name: _____ Relationship to patient: _____

Phone # (Home): (_____)_____ Phone # (Cell): (_____)_____

Emergency Contact Information:

In case of Emergency, who should be notified? _____ Relationship to patient: _____

Phone# (Home): (_____)_____ (Cell): (_____)_____

Parent or Legal Guardian Signature: _____ **Date**: _____/_____/_____