PREMIER SUBURBAN
MEDICAL GROUP

Pediatric Patient Data Information

Child's Name _____ Birth Date ____ / ____ / ____ Sex: Male Female

Child's Race: _____ Child's Ethnicity: _____

Child Resides with: ☐ Both parents ☐ Father ☐ Mother ☐ Other

Mothers Name: _____ Date of Birth: _____

Mothers Address_____ City _____ State _____ Zip _____

Fathers Name: _____ Date of Birth: _____

Fathers Address_____ City _____ State _____ Zip _____

Legal Guardian if applicable: _____ **Legal documentation required**

Address_____ City _____ State _____ Zip _____

Emergency Contact: _____ Relationship _____ Phone _____

Pharmacy (name, location, phone#) _____

Primary Care Physician Name_____ Phone_____

Primary Care Physician Address_____

Contact for Results:

I authorize Silver Cross Urgent Care to contact for results:

Parents Only ☐
_____ Home
_____ Cell
Ok to leave a message on answering machine? _____ Yes _____ No

Other ☐ Name _____ Relationship _____

Authorization to Treat: Parents/Legal Guardians please read and sign agreement:

- I hereby give my consent for the providers at Silver Cross Urgent Care to evaluate and treat the patient listed above
- I hereby authorize my insurance benefits to pay directly to Silver Cross Urgent Care, realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carrier

Signature: _____ Date _____

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Consent for Treatment

CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR

Who may bring _____ in for appointments and consent to medical treatment (including vaccines) other than the legal parent/guardian?

Name_____ Relationship to Patient _____
Address_____
Phone# _____

Name_____ Relationship to Patient _____
Address_____
Phone# _____

Name_____ Relationship to Patient _____
Address_____
Phone# _____

Name_____ Relationship to Patient _____
Address_____
Phone# _____

Parents/Legal Guardians please sign:

Signature: _____ Date: _____