PEDIATRIC PARTNERS OF WINTER HAVEN

PARENT/GUARDIAN INFORMATION CONSENT FORM

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY PEDIATRIC PARTNERS OF WINTER HAVEN OF ANY AND ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AND TO PROVIDE THE OFFICE WITH INFORMATION IF THERE ARE ANY CUSTODY RESTRICTIONS INVOLVING MY CHILD.

LAST NAME OF PATIENT (APELLIDO DEL PACIENTE) | FIRST (PRIMERO) | MI

DATE OF BIRTH (FECHA DE NACIMIENTO)

SSN (NUMERO DE SERGURO SOCIAL)

COURT ORDER ON FILE (ORDEN DE LA CORTE EN EL ARCHIVO)

STREET ADDRESS (DIRECCION) | APT# | CITY | STATE | ZIP CODE

MAILING ADDRESS (DIRECCION DE CORREO) | APT# | CITY | STATE | ZIP CODE

THE PEOPLE BELOW ARE THE ONLY ONES WHO MAY BE ALLOWED TO SEEK MEDICAL CARE AND/OR TREATMENT FOR MY CHILD AT PEDIATRIC PARTNERS. I ALSO UNDERSTAND A PHOTO COPY OF THE INDIVIDUALS WILL BE REQUIRED AT EACH VISIT AND A COPY WILL BE MADE AND PLACED IN MY CHILD'S CHART. PLEASE NOTE: ANYONE YOU ARE GRANTING PERMISSION TO MUST BE OVER THE AGE OF 18.

FATHER'S NAME (NOMBRE DE PADRE) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

MOTHER'S NAME (NOMBRE DE MADRE) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

CHILD LIVES WITH (PACIENTE VIVE CON) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

PLEASE LIST ANY SIBLINGS OF THIS CHILD WHO ALSO COME TO OUR OFFICE.

CHILD'S NAME (NOMBRE DEL NINO) | DOB (FECHA DE NACIMIENTO)

CHILD'S NAME (NOMBRE DEL NINO) | DOB (FECHA DE NACIMIENTO)

CHILD'S NAME (NOMBRE DEL NINO) | DOB (FECHA DE NACIMIENTO)

pediatricpartners

P. 863.293.2144 :: F. 863.293.3732
550 POPE AVE NW :: STE 100 :: WINTER HAVEN, FL 33881

PEDIATRIC PARTNERS OF WINTER HAVEN

OTHER PERSONS THAT YOU CONSENT TO BRING CHILD IN: (MUST BE 18 YEARS OLD OR OLDER)

OTHER (NAME) (OTRO) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

OTHER (NAME) (OTRO) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

OTHER (NAME) (OTRO) | HOME PHONE (TELEFONO) | CELL PHONE | WORK PHONE/OTHER

RELATIONSHIP TO CHILD (RELACION AL PACIENTE)

IN CASE OF INCIDENT WHERE I AM NOT ABLE TO BRING MY CHILD FOR HIS/HER APPOINTMENT, OR IF EMERGENCY TREATMENT IS REQUIRED, I UNDERSTAND THAT ONE OF THE OTHER PERSONS LISTED ON THE OTHER SIDE OF THIS FORM WILL BE ALLOWED TO ARRANGE AND SEEK TREATMENT FOR MY CHILD.

BY SIGNING BELOW, I AM AWARE THAT IT IS SOLELY MY RESPONSIBILITY TO NOTIFY PEDIATRIC PARTNERS OF ANY/ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AS WELL AS ALL FINANCIAL RESPONSIBILITIES AND TO PROVIDE THE OFFICE WITH ANY AND ALL CUSTODY RESTRICTIONS INVOLVING MY CHILD.

(PRINT) PARENT/GUARDIAN NAME (GUARDIAN NOMBRE)

RELATIONSHIP TO PATIENT (RELACION AL PACIENTE)

SIGNATURE OF PARENT/GUARDIAN (LA FIRMA)

DATE (LA FECHA)

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