GAINESVILLE PEDIATRIC ASSOCIATES, Inc

Parent/Guardian Information
*Please List All Parents

Date _____

Parent/Guardian _____ Relationship to Patient(s) _____ D.O.B. _____

Mailing Address _____ Cell # _____

City _____ State _____ Zip _____

Employer _____ Occupation _____ Phone _____

Parent/Guardian _____ Relationship to Patient(s) _____ D.O.B. _____

Mailing Address _____ Cell # _____
(IF DIFFERENT FROM ABOVE)

Employer _____ Occupation _____ Phone _____

Home Phone _____ Email Address _____

Insurance Company _____ Member ID _____

Emergency Contact: (If unable to contact the parent/guardian)

Name _____ Phone _____

Pharmacy Preference _____

Please list names of all children in family	Gender	D.O.B.	Contact Number if 18yrs or older

Consent and Treatment

I hereby authorize Gainesville Pediatric Associates and its agents, assistants or its designees to perform such professional diagnostic, laboratory, medical, surgical, and x-ray procedures as are necessary in its judgement to each of the minor children named above now and in the future when such children are brought to Gainesville Pediatric Associates.

Signature _____

Responsibility for Payment

The undersigned hereby acknowledge responsibilty for the payment of all debts incurred in the treatment of the above named children, which such children are brought to Gainesville Pediatric Associates from time to time for medical treatment.

Signature _____

Whom may we thank for referring you: _____