NORTHERN ARIZONA DERMATOLOGY CENTER

MINOR PATIENT INFORMATION

Today's Date: _____/_____/_____

CHILD'S NAME: **_____Prefer to be called:_____**
Last *First* *M.I*

Date of Birth: _____/_____/_____ SEX: ___M ___F

Parent or Legal Guardian Name:_____

Relation to Child:_____

Mailing Address: _____City:_____ State:_____ Zip Code:_____

Preferred Phone Number: _____ Is this number a: Cell __ Home__ Work__

E-mail:_____

Name & phone # of child's primary care provider:_____

How did you hear about our practice: _____

Child's Preferred Language: _____ Race:_____ Ethnicity: Non-Hispanic /Hispanic

Insurance Coverage – PRIMARY:

Primary Insurance: _____

Name of Policy Holder (Insured) _____Policy Holder D.O.B. _____/_____/_____

Policy #: _____ Group Name or #: _____

Child's Relationship to Policy Holder: **_____**

Insurance Coverage – SECONDARY:

Secondary Insurance:_____

Name of Policy Holder (Insured)_____Policy Holder D.O.B. _____/_____/_____

Policy #: _____ Group Name or #: _____

Child's Relationship to Policy Holder:_____

SIGNATURE: Parent or Legal Guardian:_____

DATE: _____

*** NADC adheres to the standards set forth in the Notice of Privacy Practices presented to you as part of HIPAA (Health Insurance Portability and Accountability Act of 1996)**