MEDICAL RELEASE FORM

(Please Print)

Today's date:			Primary Care Physician:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Home phone no.: ( )		Cell phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Date of Last Tetanus Shot:						
Current Medical Problems:						
Medication being used (include dosage/Frequency)						
Allergies:						
Present State of Health:						

INSURANCE INFORMATION					
(Please be sure you are carrying your medical card with you throughout your trip.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

AUTHORIZATION FOR TREATMENT OF A MINOR			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I, the undersigned, as the parent or legal guardian of _____, a minor, do hereby consent to the nurse or physician selected by _____ to perform routine tests and treatment for the health of my child. In the event I cannot be reached in an Emergency, I hereby give permission for the physician selected by _____ to hospitalize and secure proper treatments for, and to order injection, anesthesia, or surgery for my child as named above.

In the event of any emergencies, the undersigned hereby grants authority to be exercised at the discretion of _____to dispense over-the-counter medication.

Patient/Guardian signature *Date*