

Chart No _____

**NORTHEAST ORTHOPAEDICS, P.A.
CHILD'S FORM**

Date _____

PATIENT INFORMATION:

Last Name _____ First _____ MI _____ DOB: _____
Address _____ City _____ State _____ Zip _____ Age _____
S.S.# _____

FATHER'S INFORMATION:

Last Name _____ First _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone No.() _____ Work No.() _____ S.S.# _____
DOB: _____

MOTHER'S INFORMATION:

Last Name _____ First _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone No.() _____ Work No.() _____ S.S.# _____
DOB: _____

Person responsible for paying bill: _____ Co-pay _____ (Required at time of visit)
Primary Insurance _____ ID/Policy No _____ Group No _____
Name of Insured _____ Insurance Address _____
Secondary Insurance _____ ID/Policy No _____ Group No _____
Name of Insured _____ Insurance Address _____

I GIVE PERMISSION FOR DR. JAMES S. MCHONE TO TREAT MY CHILD. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY THE NORTHEAST ORTHOPAEDICS, PA. AS NECESSARY TO PROCESS ANY INSURANCE CLAIM AND REQUEST PAYMENT OF BENEFITS TO THE NORTHEAST ORTHOPAEDICS FOR SURGERY, FRACTURE FEE, OR ANY UNPAID BILLS.

Signature _____ Date _____
(Mother or Father)

Father's Employer _____ Employer's Phone # _____
Employer Address _____
Mother's Employer _____ Employer's Phone # _____
Employer & Address _____
Nearest Relative: Name _____ Address _____
Phone # _____

Full name of referring physician _____
Has patient been seen for present problem and if so where? _____
By whom? _____ Have x-rays been taken? _____

***Specific part of the body that is causing problem** _____
Date of Accident _____ How did it happen? _____
Where did injury occur? _____

CURRENT MEDICATIONS & DOSAGE: () NONE

MEDICATION ALLERGIES: () NONE

