Hamot

REGISTRATION

Patient Information

Patient Name_____ Birth Date_____/_____/_____
First Middle Last

Primary Care Physician_____ Marital Status_____ Sex_____

Address_____ Home Phone_____
Street City State Zip

Employer_____ Work Phone_____

Insurance Information

Insurance/Type of Insurance_____ Agreement/ID Number_____

Policyholder_____ Group Number_____

Policyholder Date of Birth_____ Policyholder Employer_____

General Consent for Treatment of Minors Under Age 18 Years

Patient Name_____

I am the parent or guardian of the above named minor. I voluntarily consent of his/her receipt of medical care of a routine nature from authorized professional staff of the *Hamot Medical Center* when accompanied by me. I understand that this authorization will not in any way jeopardize me, and that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

_____ _____
Parent/Guardian Signature Date Signed