Please Print **MINOR/STUDENT PATIENT INFORMATION** *Please Print*

Patient's Last Name First Name MI SSN: - - Date of Birth: / / MM DD YYYY

Street Address (No P.O. Boxes Please) ☐ Female ☐ Male

CITY STATE ZIP CODE Primary Care Physician:

Phone: ( ) Cell: ( ) E-mail:

STUDENT INFORMATION: Name of school:

☐ Full-time ☐ Part-time Address of school:

City State Zip

MOTHER'S INFORMATION:

Mother's Last Name First Name MI

SSN: - - DOB: / /

Mother's Address:

Marital Status: *please circle one:* Married Single Widowed Divorced Other

Phone: Home: Work: (ext) Cell: Pager:

E-mail: Employer:

Employer Address: Job Title/ Status

FATHER'S INFORMATION:

Father's Last Name First Name MI

SSN - - DOB: / /

Father's Address:

Marital Status: *please circle one:* Married Single Widowed Divorced Other

Phone: Home: Work: (ext) Cell: Pager:

E-mail: Employer:

Employer Address: Job Title/ Status

CONTACT IN CASE OF EMERGENCY:

Name: Relationship to Patient:

Address:

Phone: Home: ( ) Work: ( ) (ext) Cell: ( )

GUARANTOR: ☐ Mother ☐ Father ☐ Other (Specify)

Proof of guardianship must be provided

Address of Guarantor:

(If other than mother or father) Street City State Zip Code

Patient Relationship to Insured: ☐ NATURAL CHILD ☐ STEPCHILD ☐ OTHER (SPECIFY)

Signature of Parent / Guardian

/ /

Date