Viridian MD

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Viridian MD – NEW PATIENT INTAKE

Patient Name (First, Last): ____

Different Last Name from Parent?: **Y N** Date of Birth: ______________ Gender: _____

Nickname: ____________________ Primary Language: ____________________

Lives with Parent/Guardian: **Y N**

Guarantor Name: ____

Social History:

Are birth parents married to each other? **Y N**
If No, who does child live with?____

Smokers at home? **Y N**

Firearms in the home? **Y N** If Yes, are locked? **Y N**

Is patient in daycare? **Y N**

Is patient in school? **Y N**

Grade: _____________ School Name: __________________________________

Sports: ____

Pets at home? **Y N**

Type of pets? ____

Additional Children:

Print Name (First, Last) Date of Birth (MM/DD/YYYY) Age Gender

Insurance ID# _______________

Print Name (First, Last) Date of Birth (MM/DD/YYYY) Age Gender

Insurance ID# _______________

Print Name (First, Last) Date of Birth (MM/DD/YYYY) Age Gender

Insurance ID# _______________

Primary Insurance: Needed for Referrals and Lab Billing

Policy Holder's Name:_______________________________Policy Holder's D.O.B:______________

Insurance Carrier:____

ID#_______________________________ Group#____________________

Insurance Address:____

- ★ ***Viridian MD is a direct payment service. We do not bill insurance(s) for any reason.***

Contact Information:

Parent/Guardian Name (Last, First) ____

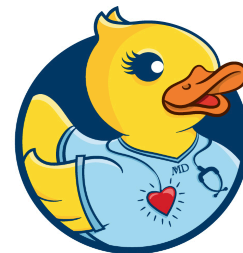
Street Address:____________________________________ City, State & Zip:__________________

Relationship to Patient:________________________________ Birthdate ______________________

Lives with Patient: **Y N** Occupation:____

Phone:Home______________________Work:____________________ Cell ____________________

Email:Home____________________________________ Work:______________________________



Parent/Guardian Name (Last, First) ____

Street Address:________________________________ City, State & Zip:________________

Relationship to Patient:____________________________ Birthdate ____________________

Lives with Patient: **Y N** Occupation:____

Phone:Home___________________Work:_________________ Cell ___________________

Email:Home________________________________ Work:___________________________

If parents are divorced or separated, please fill out this section:

Who has primary custody? ____

Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes/No**

If Yes, please explain and provide a copy of any legal paperwork that supports this restriction:

<u>Consent From Parents/Legal Guardians for Authorized Persons</u>

As the biological parent or step parent/legal guardian (court papers necessary), I am granting permission for the below listed person(s) to accompany my child/children for visits, treatment and/or care.

PLEASE CAREFULLY READ THE FOLLOWING AND INITIAL IF APPLICABLE:

_____ Initials - I am granting full permissions, meaning the below listed person(s) will be allowed to agree to treatments, and know all health history pertaining to my child/children.

*****If you do not authorize any other person aside from you, the biological parent/legal guardian, to accompany your child for any appointment and agree to treatment and health history of your child, please do not complete this section. Please be advised if any other person other than, you, the biological parent/legal guardian, accompanies the patient to any appointment without written consent, the patient will not be seen. THIS INCLUDES STEP-PARENTS, GRANDPARENTS, ETC. Staff will not be permitted to obtain any other type of consent, for example: no verbal consents will be allowed.******

OTHER NON-CUSTODIAL ADULTS WHO MAY BE AT VISIT WITH PATIENT & RECEIVE PATIENT'S HEALTH INFORMATION:

1. Full Name: ____

Relationship to Patient: ____

Phone Number: (_______)____

EMAIL: ____

2. Full Name: ____

Relationship to Patient: ____

Phone Number: (_______)____

EMAIL: ____

3. Full Name: ____

Relationship to Patient: ____

Phone Number: (_______)____

EMAIL: ____

I attest that all of the above information is true and valid at the time of completion of this form:

____
PARENT/GUARDIAN NAME (Print)

______________________________________ ____________________
PARENT/GUARDIAN SIGNATURE DATE