



# Youth Clinic

## PATIENT INFORMATION AND CONSENT FORM

Date \_\_\_\_\_

Account # \_\_\_\_\_

Child's Name	_____	Date of Birth	_____
	First M.I. Last		
Ethnicity	<input type="checkbox"/> Hispanic or Latino	Gender	M / F
	<input type="checkbox"/> Not Hispanic or Latino	Religion	_____
Race	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Other Pacific Islander	
Language	Is English your child's primary language?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Please specify	_____

Child lives with  Both Parents  Mother  Father  Other

Parents relationship to each other  Married  Divorced  Separated  Widowed  Other

Are there any custodial restrictions we need to be aware of?  No  Yes - Please specify \_\_\_\_\_

Do we have a custodial agreement on file?  Yes  No - If no, please provide agreement to our office.

Other adults(s) involved in child's life

Name \_\_\_\_\_  
First M.I. Last

Relationship \_\_\_\_\_

Name \_\_\_\_\_  
First M.I. Last

Relationship \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT IN CASE OF EMERGENCY:** In case of emergency, if I cannot be reached, the Youth Clinic has my permission to treat the members of my family as necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date