Catherine Screnci M.D. PLLC **FAMILY INTAKE FORM** **Today's Date:_____**

Name(s) of Patient(s) / Date of Birth		**Name(s) of Patient(s) / Date of Birth**	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Parent/Legal Guardian Information
First Name: _____ Last Name: _____

Relation to Patient: _____ Date of Birth: _____ Primary Language: _____

Do you live with the patient? YES □ NO □ **If NO, please place address below:

Primary Address: _____

City/Town: _____ State: _____ Zip Code: _____

Primary Phone: _____ Cell Phone: _____

Primary E-mail: _____

Employer: _____ Occupation: _____ Work Phone: _____

How would you like to be contacted about medical issues/reminders/recalls/statements?
No contact □ Mail address □ Home/Primary Phone □ Cell Phone □ Text to Cell □

Secondary Parent/Legal Guardian Information
First Name: _____ Last Name: _____

Relation to Patient: _____ Date of Birth: _____ Primary Language: _____

Do you live with the patient? YES □ NO □ **If NO, please place address below:

Primary Address: _____

City/Town: _____ State: _____ Zip Code: _____

Primary Phone: _____ Cell Phone: _____

Primary E-mail: _____

Employer: _____ Occupation: _____ Work Phone: _____

Emergency Contact (Name and Phone Number):
_____

Please Note: The accompanying parent or adult is responsible for full payment at the time of service

- Who should receive billing statements?
- May all contacts have access to patient's electronic record? YES / NO
- Is it okay to leave messages regarding patient care? YES / NO
- If parents are divorced or separated, who has custody?
- Are there any legal restrictions that would restrict non-custodial parent from consenting medical
- treatment for the child or from obtaining information about child's medical treatment? YES / NO

I hereby authorize you to treat my child/children when other caretakers escort them to your office.

Signature: _____ Date: _____