DOLPHIN PEDIATRICS, LLC
9850 STIRLING ROAD, SUITE 103
COOPER CITY, FL 33024
TEL (954) 362-3200 - FAX (954) 362-3205

PARENT/GUARDIAN INFORMATION

PLEASE WRITE **LEGIBLY** AND FILL THIS SECTION OUT **AS COMPLETELY AS YOU CAN**.

*PATIENT'S NAME*_____ *& DATE OF BIRTH*_____

	MOTHER/GUARDIAN 1	**FATHER/GUARDIAN 2**
NAME:	_____	_____
DATE OF BIRTH:	_____	_____
CEL #:	_____	_____
E-MAIL:	_____	_____
EMPLOYER:	_____	_____
WORK #:	_____	_____
LANGUAGES:	_____	_____
MARITAL STATUS:	_____	_____

If divorced, please let us know who has custody and who is responsible for the child's bills. We may ask for court papers to respect the State's decision about the child's well-being.

As long as we are able, we extend you the courtesy of calling the day before an appointment to confirm. Whose cell phone should we call? _____and do we have your permission to leave a voicemail? **Yes / No**
Who referred you to us? _____

If there is an emergency and **<u>you or another parent/guardian cannot be reached</u>**, is there anyone else you trust to **authorize emergency treatment** on your behalf?

NAME	**PHONE #**	**RELATIONSHIP TO CHILD**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you or another parent/guardian is unable to bring your child(ren) into the office for an appointment, is there anyone else you authorize to bring them in?

NAME	**RELATIONSHIP TO CHILD**
_____	_____
_____	_____

_____

SIGNATURE OF A PARENT/GUARDIAN **DATE**

CONSENT TO TREAT

I authorize the medical professionals at Dolphin Pediatrics LLC. to examine, treat, immunize, and give emergency care to my child(ren) at this facility.

_____

SIGNATURE OF PARENT/GUARDIAN or PATIENT IF 18+ **DATE**