## **DuPont Associates, P.A. Child Patient Information Form**

PLEASE PRINT:				
Child Name:	E:4	Middle	Date:	
Last	FIRST	Middle		
Date of Birth://	Sex: MF			
Home Address:				
Street	Address		City State	Zip Code
Parent One Name:				
I	ast		First	
Responsible for Payment:	Yes No			
Home Phone:		OK to leave message?	Yes	No
Work Phone:		OK to leave message?	Yes	No
Cell Phone:		OK to leave Message?	Yes	No
Parent Two Name:				
Li	st		First	
Responsible for Payment:	Yes No			
Home Phone:		OK to leave message?	Yes	No
Work Phone:		OK to leave message?	Yes	No
Cell Phone:		OK to leave Message?	Yes	No
Payment for each sessi Associates, P.A. and given to y and practitioner identification insurance purposes. Appointmentaged to the patient.	our doctor or therap will be given to you o	at every appointment. These	ments and charge statements can be	s, diagnosis c used for
DuPont Associates, P.A. does a physician or proceed to the new		•	nergency, you sho	uld call your
I HAVE READ AND AGRE	ED TO THIS POLI	CY:		
Signature:	ature: Date:			
Person Respo	usible for Payment Signature			
	DV C 1			
(For Office Use Only)	DX Code:			

January 2017