27 Hilliard Street, Manchester, CT 06042 Phone: 860-646-3903 Fax: 860-645-3492

Patient Information		
Patient Name:	Date of Birth:	Gender/Pronoun:
Primary Address:		Town:
Ethnicity:	Race:	
State:		Zip Code:
Patient email (if 16 and above):		Patient Cell:
Patient resides with: _____	Name of person responsible for bills: _____	

Parent/Guardian # 1	**Parent/Guardian # 2**
Name: DOB:	Name: DOB:
Relationship to Patient:	Relationship to Patient:
Address: ☐ same as above	Address: ☐ same as above
Town:	Town:
State: Zip Code:	State: Zip Code
Occupation/Employer:	Occupation/Employer:
Phone Number: Primary: ( )	**Phone Number:** Primary: ( )
Cell: ( ) Home: ( )	Cell: ( ) Home: ( )

Primary Insurance		
Primary Insurance:	Policy ID #:	Group #:
Policy Holder Name:	DOB:	Employer:

Financial Obligation
I understand that if payment is not received from my insurance company, or if I cannot obtain my referral, payment for all services rendered will be my financial responsibility. _____ **(initial)**

By Signing Below You Are Agreeing to the Following
Authorization to Treat Minors: I have the legal right to authorize this facility to deliver medical treatment to my child/children.
Authorization and Release: I authorize the provider to release any information including, but not limited to; the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors and/or other health practitioners.
Signature: **Date:**
☐ Parent ☐ Guardian ☐ Patient