Children's Developmental Center, P.A.

Frank A. Lopez, M.D.

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"Helping Children With Life's Ups and Downs"

PATIENT INFORMATION SHEET

Patient's Name: _____

Date of Birth: _____ Sex: Male _____ Female _____

Social Security Number: _____ Home Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Father's Name: _____

Work Number: _____ Cell Number: _____

Mother's Name: _____

Work Number: _____ Cell Number: _____

Father's Social Security #: _____ Mother's Social Security #: _____

Guardian (If different from above): _____

Guardian's Social Security #: _____ Phone Number: _____

1) I authorize the employees of Children's Developmental Center, P. A. to perform a complete history, physical exam and evaluation.
2) I acknowledge that records concerning the patient are the property of Children's Developmental Center, P.A. and are maintained for their use in providing care and treatment of the patient.
3) I hereby authorize Children's Developmental Center, P.A. to release these records to the patient's primary physician, the insurance company, and to any other individual or goverment agency that may be responsible for payment or care and treatment rendered.

I understand and agree with the above statements.

Parent / Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____