MRN #:_____

Parent, or Legal Guardian, please complete this form if patient is under 19

Patient name:_____ **Patient Date of Birth:_____**

Mother's Name:_____ Father's Name: _____

Mother's Address:_____ Father's Address:_____

City/State/Zip:_____ City/State/Zip:_____

Mother's Home Phone #:_____ Father's Home Phone #:_____

Mother's Work Phone #:_____ Father's Work Phone #:_____

Mother's Cell Phone #_____ Father's Cell Phone #:_____

Mother's Date of Birth:_____ Father's Date of Birth:_____

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

Mother's Employer:_____ Father's Employer:_____

Employer's Address:_____ Employer's Address:_____

_____ _____

Guarantor of this Account: Yes_____ No_____ Guarantor of this Account: Yes_____ No_____

The FollowMyHealth patient portal is designed to enhance secure communication with our clinic and provide easier access to patient health information. Please provide an e-mail address below if you would like access to the patient portal as an authorized individual. Some features will terminate when the patient turns 19 years old.

Mother's Email Address:_____

Father's Email Address:_____

Advanced Authorization:
We understand that a parent, or legal guardian, may not always be with the minor patient at appointments. By initialing below box, I am authorizing New West Sports Medicine & Orthopaedic Surgery to move forward with any diagnostic or treatment recommendations the provider deems medically necessary.

_____ I am authorizing New West Sports Medicine & Orthopaedic Surgery to diagnose and treat the minor patient even if a parent, or legal guardian, is not present.

_____ _____ _____

Signature of Legally Responsible Representative **Date** **Relationship to patient**