8734 Lee Vista Blvd. Suite 400 Orlando, FL 32829
Tel:(407) 910-2340   Fax: (407) 237-0944

PATIENT INFORMATION FORM: Page 2

Child's Name		D.O.B.
Pharmacy Information: All prescriptions will be sent electronically - you will no longer receive paper prescriptions		
Name of Pharmacy		Phone Number:
Address/Location		
City, State, Zip Code		

Please provide the Name and Relationship of the person/persons authorized to accompany your child to the office for sick and well visits.				
Name of person	Phone Number	Relationship to child	Authorizing Consent to Treat (circle one)	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
Parent/Guardian Signature				
I give my permission to the above stated person/persons to sign for medical treatment of my child should the need arise during my absence. I authorize Santiago A Jimenez, MD., and Janinna M Torres, MD., to perform any necessary emergency care for my child and/or children, named above, if I am unable to be located at the time of the need for such emergency medical care. I agree to the terms of the Office Financial Policy.				
X		Date		