SILOAM HEALTH
MELROSE

PEDIATRIC Patient Information

Patient's Last Name _____ First _____ Middle _____

Date of Birth (month) _____ (day) _____ (year) _____ Social Security Number _____-_____-_____

Current Street Address _____ Apt. # _____

City_____ State _____ Zip _____ County _____

Primary Phone _____ Secondary Phone _____

Work Phone _____ Ext. _____ Email address _____

The patient is a: ○ Male ○ Female

The patient is: ○ Married ○ Single ○ Divorced ○ Widowed ○ Other _____

If patient is married, name of wife or husband: _____

What is the patient's country of birth? _____

What is the patient's primary language? _____

Please mark the racial or ethnic group with which the patient identifies:

○ White (Caucasian, Middle Eastern, North African) ○ Latinx/ Hispanic ○ Asian
○ Black (African-American, African origins, Afro-Hispanics) ○ Multiracial
○ Native American/ Alaskan ○ Pacific Islander/ Hawaiian ○ Other

Is the patient currently working? ○ No ○ Yes If yes, where? _____

Does the patient have any Insurance or TennCare? ○ No ○ Yes (If yes, please show card to front desk.)

Who refers the patient to this clinic? _____

Other places where patient has received care: _____

1ST PARENT/LEGAL GUARDIAN INFORMATION

Is this parent/legal guardian a patient here at Siloam? ○ Yes ○ No

Last Name _____ First _____ Middle _____

Date of Birth (month) _____ (day) _____ (year) _____ Social Security Number _____-_____-_____

Current Street Address _____ Apt. # _____

City_____ State _____ Zip _____ County _____

Primary Phone _____ Secondary Phone _____

Work Phone _____ Ext. _____ Email address _____

Relationship to Patient _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Other _____

If patient is in the care of someone other than a biological parent, please provide legal documentation of guardianship/legal custody.

2ND PARENT/LEGAL GUARDIAN INFORMATION (If Applicable)

Is this parent/legal guardian a patient here at Siloam? ○ Yes ○ No

Last Name _____ First _____ Middle _____

Date of Birth (month) _____ (day) _____ (year) _____ Social Security Number _____-_____-_____

Current Street Address _____ Apt. # _____

City _____ State _____ Zip _____ County _____

Primary Phone _____ Secondary Phone _____

Work Phone _____ Ext. _____ Email address _____

Relationship to Patient _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Other _____

If patient is in the care of someone other than a biological parent, please provide legal documentation of guardianship/legal custody.

Sliding Fee Program

Please provide the following information for the patient and ALL FAMILY members living in the patient's house

#	Names (Including patient)	Age	Sex (M/F)	A patient at Siloam? (Y/N)	Relation to patient?	Name of Employer	Monthly income from all jobs or other sources such as Social Security, Pensions, Investments, Child Support or Alimony	Name of Health Insurance Company
1								
2								
3								
4								
5								
						Total income →		

X_____ Today's Date ____/____/_____

(Signature of patient, parent or guardian)

Your signature on this form certifies this information is true and Siloam has permission to verify through other resources.

SILOAM HEALTH
MELROSE

DESIGNEES FOR MINOR:
AUTHORIZATION FOR AGENT TO CONSENT
TO TREATMENT AND TRANSPORTATION

Patient Name:	Date of Birth: / /

As parents/legal guardians of children who are patients at Siloam Health, you may give permission in advance for certain individuals (over the age of 18) to accompany your child/children to Siloam Health for their healthcare services when you cannot be present. Please list those individuals below.

Designees:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

ONLY FOR 15 YEARS OF AGE AND OLDER

For children 15 years of age and older, you may give permission in advance for the minor patients to be designees for themselves.

Do you authorize this patient who is 15 years of age and older to come to Siloam Health and to consent to treatment in your absence?

YES _____ NO _____

I request and authorize Siloam Health and its personnel to deliver healthcare services in my absence to my child named above when accompanied by any of the following persons I have designated. I understand that as a result of my authorization these "Designees" have the ability to make medical and treatment decisions regarding my child. They also may obtain, have access to or become aware of my child's protected health information and information regarding my child's billing account with Siloam Health. I understand that it is my responsibility to contact Siloam Health to remove names from this form, as needed, otherwise the "Designees for Minor" as shown will be honored.

X_____ _____/_____/_____

Signature of Parent or guardian of patient under the age of 18 (Today's Date)

_____

Identify the relationship if signed by anyone other than patient (parent, legal guardian, caseworker, etc.)

This signed agreement will remain active for one year after it has been signed.