Grandview Family Practice

4500 Pine Avenue • Erie, PA 16504 • (814) 877-5800 • Fax: (814) 877-5809

Sharon M. Bruno, MD
Hanna Dmochowska, MD
Michele J. Tomczak, DO

PEDIATRIC INFORMATION

Patients Name_____Primary Care Physician _____

Birth Date _____ Sex _____ Social Security Number _____

Address _____ Phone Number _____
Street City State Zip

Fathers Name _____Date of Birth _____SS#_____

Address _____ Home Phone _____
Street City State Zip

Employer _____ Work Phone _____

Mother Name _____Date of Birth _____SS#_____

Address _____Home Phone _____
Street City State Zip

Employer _____ Work Phone _____

Insurance _____ Agreement/ID Number _____

Policyholder _____ D.O.B. _____ Group No._____

Policyholder's employer _____

In case of **EMERGENCY PLEASE** notify (other than parent)
Name _____ Relationship _____ Home phone _____

Address _____ Work phone _____
Street City State Zip

GENERAL CONSENT FOR TREATMENT OF MINORS UNDER AGE 18 YEARS

Patient's name _____

I am the parent or guardian of the above named minor. I voluntarily consent to his/her receipt of medical care of a routine nature from authorized professional staff of the Grandview Family Practice whether or not accompanied by me. I understand that this authorization and consent will not in any way jeopardize me, and that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

_____ _____
SIGNATURE Date

Hamot