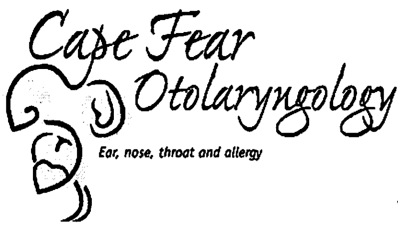

PATIENT NAME	RACE	MARITAL STATUS S M W DIV SEP	DATE OF BIRTH	SSN

STREET ADDRESS	PRIMARY PHONE NUMBER

PO BOX	CITY	STATE	ZIP CODE

EMAIL

SPOUSE'S NAME	SPOUSE DOB	SPOUSE SSN (TRICARE ONLY)

EMERGENCY CONTACT	NUMBER	RELATIONSHIP

BELOW PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM/RELEASE GENERAL MEDICAL INFORMATION TO:

NAME (OPTION 1)	RELATIONSHIP	NAME (OPTION 2).	RELATIONSHIP

IF THE PATIENT IS A MINOR (PLEASE COMPLETE BELOW)

MOTHER'S NAME	STREET ADDRESS, CITY, STATE & ZIP CODE	DOB	PHONE NUMBER
FATHER'S NAME	STREET ADDRESS, CITY, STATE & ZIP CODE	DOB	PHONE NUMBER

I hereby give my consent for the following individuals to bring my child to: **CAPE FEAR OTOLARYNGOLOGY** For treatment of illnesses, injuries, or allergies. This agreement will remain in effect until I authorize cancellation by having this consent form removed from or updated in the chart.

Below are the names and relationships, whom may accompany my child:

Person(s) Authorized	**Relationship**

Patient/Guardian ______________________ **Signature:** ____________________ **Date:** __________
(Print)

2053 Valleygate Drive Ste 101 Fayetteville NC . 28304 Ph. 910.323.9222 Fax 910.354.1680