

Patient Name: _____ **Date of Birth** _____
(Please Print)

PEDIATRIC PATIENTS ONLY:	
Mother (or Legal Designee): _____	(Please Print)
Father (or Legal Designee): _____	(Please Print)

How our office should reach you:

Primary ()	Type: Home Mobile Work	May we leave a message or voice mail? Circle: Yes or No
Other ()	Type: Home Mobile Work	May we leave a message or voice mail? Circle: Yes or No
Other ()	Type: Home Mobile Work	May we leave a message or voice mail? Circle: Yes or No
Other ()	Type: Home Mobile Work	May we leave a message or voice mail? Circle: Yes or No

SHARE: (List the full name of the family members and/or friends who are or may be involved with your care that Otsego Memorial Hospital may share your health information with)

DO NOT SHARE MY HEALTH INFORMATION WITH THE FOLLOWING: (List the full name)

My signature below indicates I have completed the above sections to the best of my ability. I understand that I may change the responses provided at any time by making a change in writing.

Signature of Patient, Parent, or Legal Guardian

Date

Printed Name of Parent or Legal Guardian

Date