Demographic Updates Form

Please notify our office promptly if any information below changes.

Child's First Name: ___________________________ **MI:** _________ **Last Name:** _____________________________

Date of Birth (mm/dd/yyyy)_________________________ **Email:** ____

Phone Number: ____________________________**(h)** _________________________ **(c)** _____________________**(w)**

Home Address: ____

(Street) *(City)* *(State)* *(Zip)*

Authorized Individuals:

Please list anyone other than parents and legal guardians who may accompany the above listed patient to appointments, receive medical information/advice, and/or schedule appointments.

	Contact Name	Contact Relationship	Contact Phone Number
Emergency Contact			
Contact #2			
Contact #3			
Contact #4			

I understand that any person who is not a legal guardian of my child or whose name does not appear on the Authorized Individuals list will not be given access to any medical information, will not be allowed to schedule appointments, or be allowed to accompany my child for treatment without further written permission. **Initial**: ________

Consent to Treat

I attest that I am the parent or legal guardian of the patient named above and have the authority to make healthcare decisions on behalf of my child. I hereby authorize the providers and clinical staff of South Carolina Pediatric Alliance to evaluate, examine, diagnose, and provide medical care and treatment to my child as deemed medically necessary by the provider. I understand that this consent includes routine care and any non-emergency treatment required during my child's visit. This consent will remain in effect unless revoked in writing.

Name of Person completing form (Printed): ____

Authorized Signature: ____ **Date:** ______________________

Patient or Parent/Guardian if patient is under the age of 16