

### Privacy Information

Please write information for all children in the family who are currently patients at PPG.

**Patient Name:** \_\_\_\_\_  
(First) (Last) (DOB)

**Patient Name:** \_\_\_\_\_  
(First) (Last) (DOB)

**Patient Name:** \_\_\_\_\_  
(First) (Last) (DOB)

**Patient Name:** \_\_\_\_\_  
(First) (Last) (DOB)

**Mother's Name:** \_\_\_\_\_  
(First) (Last) (Maiden)

Address same as patient? Yes No : \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

OK to contact? Yes No

**Father's Name:** \_\_\_\_\_  
(First) (M.I.) (Last)

Address same as patient? Yes No : \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

OK to contact? Yes No

Any other person you authorize us to communicate with:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Do you give us permission to leave a message with medical information (lab results, follow up calls, appointment confirmation)? Yes No

Who with? \_\_\_\_\_

Do you give us permission to leave a message re: billing/ins issues? Yes No

Who with? \_\_\_\_\_

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_