

Bright Stars Pediatrics, PA

Contact Information & Consent Form

Cell Phone: _____

May we leave a message? YES/NO (circle one)

Home Phone: _____

May we leave a message? YES/NO (circle one)

Work Phone: _____

May we leave a message? YES/NO (circle one)

Other #'s: _____

May we leave a message? YES/NO (circle one) May we fax to this number? YES/NO (circle one)

School Name: _____

School #: _____ Fax #: _____

May we fax to this number? YES/NO (circle one)

Email address: _____

May we email to this address? YES/NO (circle one)

*In the event a family member or caregiver attends my child's office visit and is in the exam room at the time of his/her evaluation and/or treatment, I give Dr. Karen Pilgrim-King and her staff, my permission to discuss freely my child's condition, treatment, or diagnosis with that person: **YES/NO** (circle one)*

PLEASE INDICATE THE NAME(S) OF THE INDIVIDUAL(S) WHO ARE AUTHORIZED TO CONSENT FOR TREATMENT (OTHER THAN PARENT/GUARDIAN):

Name: _____ Phone # _____ Relationship to Patient: _____

Name: _____ Phone # _____ Relationship to Patient: _____

Name: _____ Phone # _____ Relationship to Patient: _____

Name: _____ Phone # _____ Relationship to Patient: _____

Patient's Name (**PRINT**)

Parent/Guardian (**SIGNATURE**)