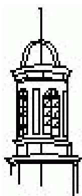

MICHAEL L. LACCHEO, M.D., P.A.

FELLOW, AMERICAN ACADEMY OF FAMILY PHYSICIANS

The Jos. Warren Building
1119 SW Gage Boulevard, Topeka, KS 66604
(785) 271-6000

MINOR PATIENT INFORMATION

PLEASE PRINT

Name ____

First Middle Last

Address ____

Street City State Zipcode

____

☐M ☐F ____________ ____________ ____________

Sex **Date of Birth** **HomePhone** **Cell Phone**

Father ____

First MI Last Date of Birth Work Phone Cell Phone

Mother ____

First MI Last Date of Birth Work Phone Cell Phone

LIST ALL SIBLINGS

First Name	Last Name	Date of Birth	First Name	Last Name	Date of Birth

____

PRIMARY INSURANCE COMPANY Policy# or ID # Group # Policyholder

____

____

SECONDARY INSURANCE Policy# or ID # Group # Policyholder

******BY SIGNING BELOW, I UNDERSTAND THAT AFTER THE INSURANCE COMPANY PAYS ACCORDING TO THE CONTRACT OF THE POLICY, I AM FULLY RESPONSIBLE FOR PAYMENT OF THE REMAINING ACCOUNT BALANCE IN A TIMELY FASHION******

______________________________ Date _____/_____/_____

Signature of Parent/Legal Guardian

______________________________ Date _____/_____/_____

______________________________ Date _____/_____/_____

______________________________ Date _____/_____/_____

______________________________ Date _____/_____/_____