SHARAD R VYAS, MD

2186 Harris Ave NE Suite 2, Palm Bay, FL 32905
321-725-8111

Patient Name: First:_____Middle: _____Last:_____

Address:_____City:_____State:_____Zip:_____

Date of Birth: _____/_____/_____Gender:_____ Soc Sec # _____ -_____- _____

PARENT/GUARDIAN'S INFORMATION:

Mother's Name: First:_____Middle: _____Last:_____

Address:_____City:_____State:_____Zip:_____

Soc Sec # _____ -_____- _____Date of Birth:_____

Cell Phone: _____Email:_____

Father's Name: First:_____Middle:_____Last:_____

Address:_____City:_____State:_____Zip:_____

Soc Sec # _____ -_____- _____Date of Birth:_____

Cell Phone: _____Email:_____

Patient's_Race:___American Indian_or_Alaska_Native: ◯ Asian: ◯ Native Hawaiian: ◯ White: ◯

Black or African_American: ◯ Other Pacific Islander: ◯ Prefer not to answer: ◯

Ethnicity: Hispanic/Latino: ◯ Non-Hispanic/Latino: ◯ Prefer not to answer: ◯

Primary Language:_English: ◯ Spanish: ◯ French: ◯ Indian: ◯ Other: ◯

Preferred Pharmacy:_____Location_____Phone:_____

Insurance Information: Primary Insurance Co:_____Policy#_____

Policy Holder Name:_____DOB:_____/____/_____Soc. Sec. _____

Secondary Insurance Co:_____Policy#_____

Policy Holder Name:_____DOB:_____/____/_____Soc. Sec. #_____

Patient referred by:_____ Self referral: Yes ◯ No ◯

We ask all patients to show their insurance cards and a parent/guardian picture ID so we may take copies

MEDICAL CONSENT FORM FOR MINOR CHILD

Name of Child: _____

Date of Birth:_____

The following individuals have my permission to bring above named child to doctor appointments and make all medical decisions for the child.

(1)Name:_____Relationship:_____

Tel:_____

(2) Name:_____Relationship:_____

Tel:_____

(3) Name:_____ Relationship:_____

Tel:_____

Signature: _____ Date:_____

Name of Parent/Guardian: (Please Print) _____

Relationship to Child: _____

Please add the above person/persons who have permission to bring the child to the

Hippa release form on the next page.