CLEFT and CRANIOFACIAL INSTITUTE OF UTAH

Today's date: Last team appointment:

PATIENT INFORMATION

Last name:	First Name:	❑Male ❑Female	Parent/Guardian Name:
Birth Date: / Age:	Primary Phone No:	Secondary Phone No.	
Street address:	Email Address:		
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	

How did you hear about our team? ❑ Doctor Referral ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other:

Other family members seen here:

INSURANCE INFORMATION

Primary Insurance Holder Name:	Birth date:	Address (if different):	Home phone no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse × Child	❑ Other
Insurance Company:		Policy ID#:	Group #:
Secondary Insurance Holder Name:	Birth date: / /	Address (if different):	Home phone no.: ( )
Insurance Company:		Policy ID#:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse ❑ Child	❑ Other

MEDICAL HISTORY

Diagnosis:	Other relevant medical history:

I hereby authorize Dr. Devan Griner, Dr. Jordan Schramm, Dr. Brian Graf, Dr. Trace Lund, Dr. Jared Rasmussen, Sarah Cordingley and Kamaile Hiatt to release to my insurance carrier any medical information necessary to secure payment. I authorize benefits to be made payable directly to Dr. Devan Griner, Dr. Jordan Schramm, Dr. Brian Graf, Dr. Trace Lund, Dr. Jared Rasmussen, Sarah Cordingley and Kamaile Hiatt. I understand that I am finacially responsible to the physician for charges not covered by my insurance policy. I certify that all information given on the patient information sheet is complete and correct to the best of my knowledge. In the event of default of payment of charges the responsible party agrees to pay collections fees including reasonable attorney fees. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an origional.

I hereby give permission to Dr. Devan Griner, Dr. Jordan Schramm, Dr. Brian Graf, Dr. Trace Lund, Dr. Jared Rasmussen, Sarah Cordingley and Kamaile Hiatt to render treatment as he/she sees fit upon myself, my son or daughter or anyone else I have guardianship over, and to call any consultant or anesthesiologist, laboratory personnel, etc. as he deems advisable in the care of this case. I also give permission for Dr. Devan Griner, Dr. Jordan Schramm, Dr. Brian Graf, Dr. Trace Lund, Dr. Jared Rasmussen, Sarah Cordingley and Kamaile Hiatt to take and use, as he deems proper, photographs, pertinent to this case. I am advised that though results are expected, they cannot be and are not guaranteed, nor is there any guarantee against untoward results. I understand that my contract is between Dr. Devan Griner, Dr. Jordan Schramm, Dr. Brian Graf, Dr. Trace Lund, Dr. Jared Rasmussen, Sarah Cordingley and Kamaile Hiatt and myself.

Parent/Guardian Signature Date