

Grew, Morter & Hartye PA  
3141 John Humphries Wynd, Suite 275  
Raleigh, North Carolina 27612

**CLIENT INFORMATION (Child/Minor Client)**

Name: \_\_\_\_\_  
Last First Middle

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

Parent Home Phone: \_\_\_\_\_ \*May we leave messages at this number? Yes No

Parent Work or Cell Phone: \_\_\_\_\_ \*May we leave messages at this number? Yes No

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Preferred Pronoun (he, she, they, other): \_\_\_\_\_

Ethnic Group (Optional): \_\_\_\_\_ School/Work: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone: \_\_\_\_\_

\*May your GMH provider contact your PCP in order to coordinate your care (a release form will need to be signed)? \_\_\_ YES \_\_\_ NO (if No, please initial here): \_\_\_\_\_

**EMERGENCY CONTACT(S):**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Client \_\_\_\_\_

**RESPONSIBLE PARTY:**

Name: \_\_\_\_\_  
Last First Middle

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

Home Phone: \_\_\_\_\_ \*May we leave messages at this number? Yes No

Work or Cell Phone: \_\_\_\_\_ \*May we leave messages at this number? Yes No

Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Customer Service or Member Benefits Phone Number: \_\_\_\_\_

**RELEASE OF INFORMATION:** I hereby authorize the release of any information necessary to process any insurance claims for payment. I understand that this may include detailed information regarding my condition and/or treatment. I understand that I am responsible for payment of GMH fees if the insurance company denies payment on claims. **I understand that I am responsible for payment of late cancellation/missed appointment fees of \$69.**

SIGNATURE OF PARENT/GUARDIAN (Policyholder for Child): \_\_\_\_\_ DATE: \_\_\_\_\_

Print Name of Policyholder Signing: \_\_\_\_\_