

CHILDREN'S HABILITATION CENTER, P.C.
LINDA NATHANSON-LIPPITT, M.D.
PATIENT INFORMATION/AUTHORIZATION TO TREAT/PRIVACY FORM

Patient Name _____

Date of Birth _____

Home Telephone Number for Patient _____

Street Address for Patient _____

City _____ State _____ Zip Code _____

Parent/Guardian Name(s) _____

If address for either parent/guardian is different than patient, please complete:
Name and Phone Number(s) of

Parent/guardian _____

Street Address _____

City _____ State _____ Zip Code _____

Employer _____ Phone Number _____

Father Employer _____ Phone Number _____

Mother Employer _____ Phone Number _____

Other numbers in case of emergency _____

Referred by _____

Primary Care Physician (name, address & phone no.) _____

Send copy of report from evaluation to PCP? Yes _____ No _____

(It is your responsibility to inform us of any change in Primary Care Provider)

I authorize Dr. Linda Nathanson-Lippitt to evaluate and treat my child/self.

Signature _____ Date _____

This office does not share any information with any other source without written/signed authorization from you. Please sign below to authorize the doctor and staff to share information with your other physician's, therapist's, laboratory, school, etc. If you have any further questions, concerns, or requests, please contact the office staff. Thank you.

Signature of parent/guardian _____

Date _____

In order to expedite the time in which you receive the written evaluation from your child's visit(s), we can now send via password protected email. If you would like to receive via email, please provide us with a unique password specific to you & your child. This will never be shared with anyone else.

Selected password _____

Email address: _____ (Please write clearly)