

# Pediatric Partners, LLC

**Patient's Last Name:** \_\_\_\_\_

Family's Primary Contact Phone Number: \_\_\_\_\_

List Full Name of **All** Children That Are Patients Here:

|       |        |                      |
|-------|--------|----------------------|
| _____ | M or F | Date of Birth: _____ |
| _____ | M or F | Date of Birth: _____ |
| _____ | M or F | Date of Birth: _____ |
| _____ | M or F | Date of Birth: _____ |
| _____ | M or F | Date of Birth: _____ |

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

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Primary language spoken in the home:** \_\_\_\_\_

**Ethnicity:** (Circle one) Hispanic or Non-Hispanic or Decline to Answer

**Race:** (Circle all that apply) American Indian/Asian / Black / Hawaiian Native / White

## **Parent/ Guardian Information:**

**Parent 1:** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

(\*If different from patient) City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Parent 2:** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

(\*If different from patient) City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## **Emergency Contact (Other than parents):**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Alternate Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Insurance:**

Primary Insurance: \_\_\_\_\_

Policy Holder's Last Name: \_\_\_\_\_ Employer: \_\_\_\_\_

First Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**\*Please note, all state medical assistance insurance plans are always secondary to any private health insurance plan.**

Secondary Insurance: \_\_\_\_\_

Policy Holder's Last Name: \_\_\_\_\_ Employer: \_\_\_\_\_

First Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Billing statements should be sent to (If different from above):**

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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

Primary Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Privacy Constraints (Check one):**

----- No restrictions. Okay to leave message / send mail / send email

----- Restrictions: Person to person with patient / guardian only

----- Restrictions: \_\_\_\_\_

**How would you ideally prefer to be contacted regarding (Circle one):**

*Medical issues:* Home Phone / Work Phone / Cell Phone / E-mail

*Appointment Reminders:* Home Phone/ Cell Phone/ E-mail

*Well Visit Recalls:* Home Address / Home Phone / Work Phone / Cell Phone / E-mail

*Billing Statements:* Home Address / E-mail

*General Notices:* Home Address / Home Phone / Work Phone / Cell Phone / E-mail

*Patient Portal:* Cell Phone/ Home E-mail

If parents are divorced or separated, who has custody? \_\_\_\_\_

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes or No**

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

I authorize the release of any medical information necessary to process claims and payments for Pediatric Partners, LLC. I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I have been offered a copy of the Notice of Privacy Practice (HIPPA).

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_