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 (<u>Other than parents</u>):

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 <u>always</u> 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: _____