Patient Contact Information

Date:_____

Child's Name: _____ **Nickname:** _____
Last, First, MI

Date of Birth: _____ **Gender:** _____ **Primary Language:** _____

Ethnicity: _____ **Race:** _____

Insurance Policy Holder's Name_____DOB:_____Relationship to patient:_____

Insurance Co:_____Member ID_____Group No:_____Effective Date:_____

Name of pharmacy:_____Phone:_____Address:_____

Parent Contact 1: _____ **Relationship:** _____
Last, First, MI

Lives with patient? ◯Y ◯N **Social Security #:**_____ **Date of Birth:** _____

Home Address:_____ Email: _____

City _____ St _____ Zip_____ Ph#_____Preferred Language: _____

Employer: _____ Employer Phone #: _____

Parent Contact 2: _____ **Relationship:** _____
Last, First, MI

Lives with patient? ◯Y ◯N **Social Security #:**_____ **Date of Birth:** _____

Home Address:_____ Email: _____

City _____ St _____ Zip_____ Ph#_____Preferred Language: _____

Employer: _____ Employer Phone #: _____

Other Legal Guardian or Financially Responsible:

_____ **Relationship:** _____
Last, First, MI

Lives with patient? ◯Y ◯N **Social Security #:**_____ **Date of Birth:** _____

Home Address:_____ Email: _____

City _____ St _____ Zip_____ Ph#_____Preferred Language: _____

Employer: _____ Employer Phone #: _____

Who should receive billing statements? _____

May all above contacts have access to patient's records? ◯ **Yes** ◯ **No**

If parents are divorced or separated, complete:

Who has custody? _____ Are there legal restrictions preventing non-custodial parent from consenting to medical treatment for the patient or obtaining patient's medical treatment? ◯**Yes** ◯**No**. If yes, please explain and provide a copy of legal paperwork supporting this restriction:_____

_____

Telephone Numbers *#1 is the number to be called for reminder calls and messages. List numbers in the order to be called.*		
1. ( )_____◯Home ◯Cell ◯Work ◯Other:_____	□*Mother* □*Father*	□ *Name:*_____ *Relation:*_____
2. ( )_____◯Home ◯Cell ◯Work ◯Other:_____	□*Mother* □*Father*	□ *Name:*_____ *Relation:*_____
3. ( )_____◯Home ◯Cell ◯Work ◯Other:_____	□*Mother* □*Father*	□ *Name:*_____ *Relation:*_____

Siblings (who are patients at The Pediatric Place)

Last, First, DOB	Gender
_____	_____
_____	_____
_____	_____
_____	_____

Authorization for Medical Care

I authorize the following people to bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence. This does not allow them to have access to confidential health information that is not relevant for the visit. *Please check the boxes to give them additional specific authorizations.**

Name:_____ Relationship:_____ □ *May pick up prescriptions* □ *May pick up shot records*

Name:_____ Relationship:_____ □ *May pick up prescriptions* □ *May pick up shot records*

Any other documents to be picked up by non-legal guardians must have written consent.

I understand telephone triage and advice services will be extended to the above persons if regarding direct patient care while the child is in their care. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If we cannot reach you, we will not refuse treatment. This serves as consent for medical treatment we deem as medically necessary and appropriate.

Parent /Guardian Signature_____ Date_____ Relationship to pt_____

I have been given an opportunity to read the practice's HIPPA Notice of Privacy Practices and I am entitled to a personal copy if I ask for one.

Parent /Guardian Signature_____ Date: _____