



PEDIATRIC CARE PATIENT INFORMATION FORM

Patient Last Name _____ First Name _____ Patient Birthdate _____ Sex _____

Address _____ City _____ State _____ Zip code _____

Preferred Contact Number _____ Cell Phone Number(s) _____ email _____

Name of Responsible Party _____ Relationship _____ *Address of Responsible Party if Different from child _____ City _____ State _____ Zip _____

Mother's Name (Maiden Name) _____ Birthdate _____ Father's Name _____ Birthdate _____

Mother's Employer _____ Work Number _____ Father's Employer _____ Work number _____

Siblings Names and Dates of Birth _____

Please check 1 or more:

White Hispanic/Latino Black or African American American Indian/Native Alaskan Asian Other Pacific Islander Other I prefer not to answer

Primary Language Please check or fill in English other _____ I prefer not to answer

INSURANCE INFORMATION: YOU WILL BE REQUIRED TO PRESENT YOUR INSURANCE CARD AT EVERY VISIT

If your insurance requires a primary care MD PLEASE call the insurance to indicate your primary MD. If you are on an HMO you must follow HMO procedures for eligibility, referrals and emergencies. If your insurance requires a referral, please allow at least (1) one week to process proper forms.

Please note the following financial policies:

Payment or co-pay for services rendered is due at the time of service. It is our policy that the parent bringing the child will pay the co-pay at the time of service regardless of who is responsible. All returned checks will be assessed a \$25.00 fee in addition to the check amount. If there is a repeated occurrence, then all payments must be made by cash, money order or credit card.

We will bill your insurance carrier provided proper insurance information is given to us on the day of service. We will make every reasonable effort to assist you with your insurance claims; however, it is your responsibility to provide us with the correct information. If the claims are rejected you will be responsible for the balance due. We will make every reasonable effort to work with you on your balance due, if we fail to get a response from you there may be billing fees assessed. If your bill is sent to our collection agency, a recovery fee of up to 30% of the bill due may be added.

In order to provide the highest quality of care to our patients, cancellation of appointments will require 24-hour notification. We reserve the right to charge a fee for any missed appointments without 24-hour notification.

I would like to opt IN OUT **eHx** (electronic sharing of medical records) _____

Signature of Parent /Guardian/Patient

I would like to opt IN OUT **ICARE** (Immunization Registry) _____

Signature of Parent /Guardian/Patient

**** I am over 18 and I consent to the release of information to my parents** _____ **Please initial**

I agree to the above financial policies and to the assignment of Benefits and Release of information. I authorize payment of insurance benefits directly to the physician for professional services rendered. I authorize the release of any medical and other information necessary to process claims and payments.

Signature of Parent /Guardian/Patient _____

Date _____

Who can we thank for referring you? _____

Thank You for choosing Pediatric Care