PEDIATRIC CARE PATIENT INFORMATION FORM

Patient Last Name ____ First Name ____ Patient Birthdate ____ Sex ____

Address ____ City ____ State ____ Zip code ____

Preferred Contact Number ____ **Alternate** 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 RQUIRED 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 sign**

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

Please complete both sides

ecw 08/18