Pediatric & Adolescent Care

BUSINESS OFFICE USE ONLY – Updated By _____Date_____

FAMILY INFORMATION SHEET

PATIENT'S NAME	SSN	SEX	BIRTHDATE
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

LANGUAGE

- o English
- o Spanish
- o Other

ETHNICITY

- o Hispanic/Latino
- o Non-Hispanic/ Non-Latino
- o Unknown

RACE

- ○ American Indian/ Alaskan Native
- ○ Hawaiian Native/ Pacific Islander
- ○ Asian
- ○ Black
- ○ White

PREFERRED CONTACT # FOR TEXT NOTIFICATIONS _____

FATHER'S NAME _____

SSN _____ **DATE OF BIRTH** _____

ADDRESS _____ HOME PHONE (_____) _____

CITY/STATE/ZIP _____ WORK PHONE (_____) _____

EMPLOYER _____ CELL PHONE (_____) _____

OCCUPATION _____ CONTACT EMAIL _____

MOTHER'S NAME _____

SSN _____ **DATE OF BIRTH** _____

ADDRESS _____ HOME PHONE (_____) _____

CITY/STATE/ZIP _____ WORK PHONE (_____) _____

EMPLOYER _____ CELL PHONE (_____) _____

OCCUPATION _____ CONTACT EMAIL _____

- o In the event all or any portion of the balance due becomes past due, the person listed as responsible for payment on the account accepts responsibility for the full amount past due. In the case of separation or divorce, the person who brings the child in for treatment is responsible, unless otherwise noted.
- o Payment made by check/credit card is subject to a service fee of $20.00 per item in the event the check/credit card is returned as a stop payment item.
- o I have read and agree to abide by the financial policies of Pediatric and Adolescent Care, LLP.
- o I hereby give authorization to the physicians and staff of Pediatric and Adolescent Care, LLP, to treat my child(ren) with reasonable and proper medical care by today's standards (including immunizations).
- o I hereby authorize the release of any medical or other information necessary to process claims for services provided by this practice. I also authorize payment directly to my physician of the physician's benefits otherwise payable to me but not to exceed my indebtedness to said physician. I understand I am financially responsible to the physician for charges not covered by this agreement. A copy of this assignment is as valid as the original.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

PHARMACY INFORMATION

Pharmacy Preference	Location, City	Pharmacy Phone
_____	_____	(___) _____

INSURANCE INFORMATION

THIS FORM MUST BE UPDATED ANNUALLY OR WHENEVER THERE IS A CHANGE OF INSURANCE IN ORDER TO MAINTAIN A VALID AUTHORIZATION TO FILE YOUR INSURANCE. A COPY OF YOUR INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM.

INSURANCE COMPANY _____
SUBSCRIBER'S NAME _____ **DOB** _____
ID# _____ **Group #** _____ _____
EMPLOYER _____**OFFICE COPAY**_____
EFFECTIVE DATE_____ **RELATIONSHIP TO PATIENT(S)** _____

PERSON(S) RESPONSIBLE FOR THE BILL: _____

IF PARENTS ARE DIVORCED, WHICH PARENT HAS CUSTODY? _____

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PARENT/GUARDIAN SIGNATURE_____**DATE**_____

LIST THE NAMES AND PHONE NUMBERS OF TWO RELATIVES OR FRIENDS
WHOM WE MAY CONTACT IN CASE OF EMERGENCY

NAME _____ PHONE _____ RELATION _____

NAME _____ PHONE _____ RELATION _____