Pediatric & Adolescent Care

ADOLESCENT INFORMATION SHEET

PATIENT'S NAME _____ M / F BIRTHDATE _____

LANGUAGE	RACE		Ethnicity
○ English	○ American Indian/Alaskan Native	○ Black	○ Hispanic/Latino
○ Spanish	○ Hawaiian Native/Pacific Islander	○ White	○ Non-Hispanic/Non-Latino
○ Other	○ Asian		○ Unknown

PREFERRED CONTACT PHONE: _____ EMAIL: _____

PREFERRED CONTACT # FOR TEXT NOTIFICATIONS _____

ADDRESS _____ APT. _____ HOME PHONE (_____)_____

CITY/ST/ZIP _____

EMPLOYER _____ CELL PHONE (_____)_____

SOCIAL SECURITY NUMBER _____

DO WE HAVE PERMISSION TO RELEASE PERSONAL HEALTH INFORMATION TO YOUR PARENT(S) OR GUARDIAN? _____ YES _____ NO _____ WITH RESTRICTIONS *(must complete a separate form)*

Authorization above will remain in effect until rescinded in writing; or until _____.
Date Specified

INSURANCE INFORMATION

INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ DOB _____

ID # _____ OFFICE COPAY _____

EMPLOYER _____

EFFECTIVE DATE _____ RELATIONSHIP TO PATIENT _____

PHARMACY PREFERENCE	Location, City	PHARMACY PHONE
_____	_____	(_____)_____

PATIENT MUST SIGN PAGE 2

ADOLESCENT INFORMATION SHEET

FATHER'S NAME: _____ DOB _____

ADDRESS _____ HOME PHONE (_____)_____

CITY/ST/ZIP _____ CELL PHONE (_____)_____

EMPLOYER _____ WORK PHONE (_____)_____ EXT_____

JOB TITLE _____EMAIL _____

SOCIAL SECURITY NUMBER _____

MOTHER'S NAME: _____ DOB _____

ADDRESS _____ HOME PHONE (_____)_____

CITY/ST/ZIP _____ CELL PHONE (_____)_____

EMPLOYER _____ WORK PHONE (_____)_____ EXT_____

JOB TITLE _____EMAIL _____

SOCIAL SECURITY NUMBER _____

WHO SHOULD WE CONTACT FOR BILLING/INSURANCE CORRESPONDENCE OR QUESTIONS:

_____

- **In the event all or any portion of the balance due becomes past due, the patient listed above accepts responsibility for the full amount past due.**
- **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.**
- **I (we) have read and agree to abide by the financial policies of Pediatric & Adolescent Care, LLP.**
- **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 physicians 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.**

PATIENT'S SIGNATURE _____ Date _____

EMERGENCY CONTACT: Name _____ Phone _____

Business Office Use Only - Updated by _____ Date _____