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 _____

PRIMARY CONTACT

NAME _____ DATE OF BIRTH:_____

SSN _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CELL PHONE (_____) _____

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

EMPLOYER _____ OCCUPATION _____

CONTACT EMAIL _____

SECONDARY CONTACT

NAME _____ DATE OF BIRTH:_____

SSN _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CELL PHONE (_____) _____

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

EMPLOYER _____ OCCUPATION _____

CONTACT EMAIL _____

- o I have read and agree to abide by the financial policies of Pediatric and Adolescent Care, LLP.
- 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 hereby authorize 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 Pediatric & Adolescent Care, LLP to query my child's prescription history if deemed necessary.
- o I hereby authorize the release of any forms or immunization records to my child's school, upon my request.
- 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.
- o I understand both biological parents have access to full disclosure of their child's medical information and can authorize someone to bring their child to appointments in their absence.
- o I understand the providers may not be able to discuss information regarding teenage issues mentioned during an appointment, unless the physician feels the patient is a danger to themselves or others. I also understand this information will not be accessible on the patient portal.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

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FAMILY INFORMATION SHEET

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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- I hereby authorize the release of any forms or immunization records to my child's school, upon my request.
- 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.
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- I understand the providers may not be able to discuss information regarding teenage issues mentioned during an appointment, unless the physician feels the patient is a danger to themselves or others. I also understand this information will not be accessible on the patient portal.

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 _____