BUSINESS OFFICE USE ONLY	– Updated By	Date



FAMILY INFORMATION SHEET

PATIENT'S NAME	SSN	SEX	BIRTHDATE	LANGUAGE	RACE
		M/F		English	o American Indian/
				o Spanish	Alaskan Native
	_	M/F		o Other	o Hawaiian Native/
	_	M/F		ETHNICITY	Pacific Islander
		M/F		 Hispanic/Latino 	o Asian
		. 141/1		Non-Hispanic/	o Black
	_	M/F		Non-Latino	o White
		M/F		o Unknown	
PREFERRED CONTACT # FOR TEXT	NOTIFICATIONS _				
RIMARY CONTACT					
NAME			DATE OF	BIRTH:	
SSN	_ RELATIONSHIP TO	O PATIE	NT		
ADDRESS		CE	ELL PHONE ()	
CITY/STATE/ZIP		W	ORK PHONE (_)	
EMPLOYER		0	CCUPATION _		
CONTACT EMAIL					
ECONDARY CONTACT					
NAME			DATE OF	BIRTH:	
SSN	_ RELATIONSHIP TO	O PATIE	NT		
ADDRESS		CE	ELL PHONE ()	
CITY/STATE/ZIP		W	ORK PHONE (_)	
EMPLOYER		0	CCUPATION _		
CONTACT EMAIL					

- 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.
- 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.
- 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.
- 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	DΔTF

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FAMILY INFORMATION SHEET

NT NAME: DATE OF BIRTH:		DATE OF BIRTH
PHARMACY INFORMATION Pharmacy Preference	Location, City	Pharmacy Phone
		()
_	INSURANCE INFORMATI	<u>ON</u>
	LLY OR WHENEVER THERE IS A CHANGE NCE. A COPY OF YOUR INSURANCE CARE	OF INSURANCE IN ORDER TO MAINTAIN A VALID O(S) MUST BE ATTACHED TO THIS FORM.
NSURANCE COMPANY		
SUBSCRIBER'S NAME		DOB
D#	Group #	OFFICE COPAY
EMPLOYER	DEL ATIONOLIID TO DAT	ENT(S)
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I have read and agree to abide by the finand In the event all or any portion of the balance amount past due. In the case of separation Payment made by check/credit card is subjuictly I hereby authorize the physicians and staff (including immunizations). I hereby authorize Pediatric & Adolescent Composition I hereby authorize the release of any forms I hereby authorize the release of any medic to my physician of the physician's benefits of the physician for charges not covered by the I understand both biological parents have a	or divorce, the person who brings the child in for treect to a service fee of \$20.00 per item in the event to Pediatric and Adolescent Care, LLP, to treat my care, LLP to query my child's prescription history, if or immunization records to my child's school, upon all or other information necessary to process claims otherwise payable to me but not to exceed my indet is agreement. A copy of this assignment is as valid	nsible for payment on the account accepts responsibility for the full ratment is responsible, unless otherwise noted. The check/credit card is returned as a stop payment item. Shild(ren) with reasonable and proper medical care by today's standardeemed necessary. If my request, for services provided by this practice. I also authorize payment directly tedness to said physician. I understand I am financially responsible as the original.
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