

Pediatric Partners, LLC

Patient's Last Name: _____

Family's Primary Contact Phone Number: _____

List Full Name of All Children That Are Patients Here:

_____	M or F	Date of Birth: _____
_____	M or F	Date of Birth: _____
_____	M or F	Date of Birth: _____
_____	M or F	Date of Birth: _____
_____	M or F	Date of Birth: _____

Home Address: _____

City: _____ Zip Code: _____

Primary language spoken in the home: _____

Ethnicity: (Circle one) Hispanic or Non-Hispanic or Decline to Answer

Race: (Circle all that apply) American Indian/Asian / Black / Hawaiian Native / White

Parent/ Guardian Information:

Parent 1: Name: _____ Date of Birth: _____

Address: _____

(*If different from patient) City: _____ Zip Code: _____

Work Phone: _____ Cell #: _____

E-mail: _____

Employer: _____

Relationship to Patient: _____

Parent 2: Name: _____ Date of Birth: _____

Address: _____

(*If different from patient) City: _____ Zip Code: _____

Work Phone: _____ Cell #: _____

E-mail: _____

Employer: _____

Relationship to Patient: _____

Emergency Contact (Other than parents):

Name: _____ Phone #: _____

Alternate Phone #: _____ Relationship: _____

Insurance:

Primary Insurance: _____
Policy Holder's Last Name: _____ Employer: _____
First Name: _____ Relationship to Child: _____
Policy Holder's Birth Date: _____ SSN: _____
ID#: _____ Group #: _____

***Please note, all state medical assistance insurance plans are always secondary to any private health insurance plan.**

Secondary Insurance: _____
Policy Holder's Last Name: _____ Employer: _____
First Name: _____ Relationship to Child: _____
Policy Holder's Birth Date: _____ SSN: _____
ID#: _____ Group #: _____

Billing statements should be sent to (If different from above):

Name: _____
Relationship to patient: _____
Address: _____
Primary Phone: _____ Cell #: _____

Privacy Constraints (Check one):

- ___ No restrictions. Okay to leave message / send mail / send email
- ___ Restrictions: Person to person with patient / guardian only
- ___ Restrictions: _____

How would you ideally prefer to be contacted regarding (Circle one):

- Medical issues:* Home Phone / Work Phone / Cell Phone / E-mail
- Appointment Reminders:* Home Phone / Cell Phone / E-mail
- Well Visit Recalls:* Home Address / Home Phone / Work Phone / Cell Phone / E-mail
- Billing Statements:* Home Address / E-mail
- General Notices:* Home Address / Home Phone / Work Phone / Cell Phone / E-mail
- Patient Portal:* Cell Phone / Home E-mail
- Preferred Lab:* Lab Corp _____ Quest _____

If parents are divorced or separated, who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes or No**
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

I authorize the release of any medical information necessary to process claims and payments for Pediatric Partners, LLC. I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I have been offered a copy of the Notice of Privacy Practice (HIPAA).

Signature: _____ **Date:** _____