CHILD PATIENT INFORMATION **Date**_____

Name(first,middle,last)_____ Patient Cell#_____

Date of Birth_____ Age_____ Sex_____ Soc Sec#_____

Address of Child_____ Best Contact #_____

City, State_____ Zip_____ 2nd Contact #_____

Race_____ Ethnicity Hispanic / Not Hispanic Language_____ Pharm Name_____

Guarantor Email Address_____ Pharm City/Road_____

Mother's Name_____ Phone#_____

Date of Birth_____ Soc Sec#_____

Address(if different)_____ Zip_____

Employer_____ Work#_____

Father's Name_____ Phone#_____

Date of Birth_____ Soc Sec#_____

Address(if different)_____ Zip_____

Employer_____ Work#_____

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IN CASE OF EMERGENCY, WHOM MAY WE NOTIFY OTHER THAN PARENTS?

Name_____ Relationship_____

Address_____ Phone#_____

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INSURANCE INFORMATION

Policy Holder_____ Date of Birth_____

Ins Co Name_____

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WHO REFERRED YOU TO OUR PRACTICE?_____

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I understand that I am responsible for full payment of my bill in a timely manner. I authorize payment of medical benefits directly to the providing physician, or Pediatric Place, for services rendered. Pediatric Place may use my/my child's protected health information (PHI) to carry out treatment, payment and health care operations (TPO); contact my house or other designated location and leave messages to assist in providing TPO; send information and statements to my home or designated address; share my/my child's PHI with other medical providers caring for me or my child. I have the right to review Pediatric Place's Privacy Statement. I have the right to revoke my consent in writing except for disclosures already made prior to Pediatric Place receiving such notice. Pediatric Place has a right to decline treatment if consent is not given. Accounts over 60 days are assessed a monthly statement fee of $10.00.

_____ Date_____

(Signature of responsible party)