CHILD PATIENT INFORMATION **Date______________**

Name(first,middle,last)____Cell#_________________________

Date of Birth_________________________Age_________Sex_________Soc Sec#_______________________

Address of Child____Phone#________________________

City, State____Zip_______________

Guarantor Email Address____

Mother's Name____Phone#_________________________

Date of Birth________________________Soc Sec#________________________Cell#______________________________

Address(if different)____Zip__________________

Employer____Work#____________________________

Father's Name____Phone#_________________________

Date of Birth________________________Soc Sec#________________________Cell#______________________________

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 $8.00 and accounts over 90 days are additionally assessed a monthly service charge of 1.5%.

____Date______________________________

(Signature of responsible party)