HOT SPRINGS PEDIATRIC CLINIC, P.A.

PATIENT INFORMATION

TODAY'S DATE_____

CHILD'S FULL NAME _____
(FIRST) (MIDDLE) (LAST)

FOR INSURANCE PURPOSES, CHILD'S NAME MUST BE AS IT APPEARS ON THE BIRTH CERTIFICATE

SOCIAL SECURITY #_____DATE OF BIRTH_____

WHAT TYPE OF INSURANCE DOES YOUR CHILD HAVE? NAME & ID #

(IF NEWBORN, LIST WHAT INSURANCE BABY WILL HAVE)_____

PHYSICAL ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

MAILING ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

PREFERRED CELL PHONE NUMBER (_____)_____-_____ PREFERRED HOME PHONE NUMBER (_____)_____-_____

PREFERRED METHOD FOR APPOINTMENT REMINDERS: ☐ CALL ☐ TEXT ☐ MOTHER / GUARDIAN-1 EMAIL ☐ FATHER / GUARDIAN-2 EMAIL

NAME OF SCHOOL/DAYCARE_____

RACE/ETHNICITY_____ MALE_____ FEMALE_____

RESPONSIBLE PARTY INFORMATION

MOTHER/GUARDIAN'S NAME_____
(FIRST) (MIDDLE) (LAST) (MAIDEN)

PHYSICAL ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

MAILING ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

EMPLOYER/OCCUPATION _____ WORK PHONE NUMBER _____

DAYTIME PHONE NUMBER _____ NIGHTTIME PHONE NUMBER_____

EMAIL ADDRESS: _____ RACE/ETHNICITY_____

FATHER/GUARDIAN'S NAME _____
(FIRST) (MIDDLE) (LAST)

PHYSICAL ADDRESS _____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

MAILING ADDRESS _____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

EMPLOYER/OCCUPATION _____ WORK PHONE NUMBER _____

DAYTIME PHONE NUMBER _____ NIGHTTIME PHONE NUMBER _____

EMAIL ADDRESS: _____ RACE/ETHNICITY_____

IN THE EVENT OF AN EMERGENCY, PLEASE LIST SOMEONE WE CAN CONTACT OTHER THAN YOURSELF

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

PRIMARY PHONE NUMBER _____ SECONDARY PHONE NUMBER _____

IS THIS PERSON AUTHORIZED TO BRING MINOR PATIENT IN FOR MEDICAL CARE, TREATMENT AND/OR ADMINISTRATION OF IMMUNIZATIONS? **YES** or **NO**

PREFERRED CHOICE OF PHARMACY: NAME_____ **LOCATION**_____

SECONDARY CHOICE OF PHARMACY: NAME_____ **LOCATION**_____

TURN OVER

HOT SPRINGS PEDIATRIC CLINIC, P.A.

PATIENT'S NAME_____ **DATE OF BIRTH**_____

OTHER IMPORTANT PHONE NUMBERS _____
(NAME) (PRIMARY PHONE NUMBER)

_____
(NAME) (PRIMARY PHONE NUMBER)

IS ANYONE, OTHER THAN THE PARENTS/GUARDIANS, AUTHORIZED TO BRING YOUR CHILD TO THIS OFFICE FOR MEDICAL CARE AND/OR THE ADMINISTRATION OF IMMUNIZATIONS? **YES** or **NO**
IF YES, PLEASE LIST THE NAME(S) AND RELATIONSHIP (S) TO THE PATIENT:

PLEASE LIST THE NAMES AND DATES OF BIRTH OF OTHER CHILDREN IN YOUR FAMILY:

IF YOUR CHILD (CHILDREN) COMES TO THE CLINIC WITH SOMEONE OTHER THAN THE PARENT/GURADIAN, THAT PERSON WILL BE EXPECTED TO SETTLE THE OFFICE VISIT COST AT THE TIME OF SERVICE.

ACKNOWLEDGEMENT OF CLINIC APPOINTMENT POLICY:

We require notification that a patient is unable to keep a scheduled appointment as soon as possible and a minimum notice of two (2) hours prior to the scheduled appointment time or the appointment will be counted as a No-Show. Two (2) No-Show appointments is considered excessive and cause for dismissal.

I UNDERSTAND THE ABOVE POLICY AND AGREE TO CONTACT THE CLINIC AS SOON AS POSSIBLE AND, AT THE MINIMUM, TWO HOURS PRIOR TO A SCHEDULED APPOINTMENT IF THE PATIENT IS UNABLE TO KEEP THE APPOINTMENT OR NEEDS TO RESCHEDULE.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____ _____
PRINTED NAME **RELATIONSHIP**

AUTHORIZATION AND RELEASE

* **I AUTHORIZE THE RELEASE AND/OR THE REQUEST OF ANY INFORMATION INCLUDING THE HISTORY, IMMUNIZATION RECORD, EXAMINATIONS, DIAGNOSIS, AND TREATMENT RENDERED TO MY CHILD TO THIRD PARTY PAYORS, OTHER HEALTH PRACTITIONERS, AND/OR PUBLIC OR PRIVATE SCHOOL IN WHICH MY CHILD ATTENDS OR HAS ATTENDED.**
* **I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR OR DOCTORS'S GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.**
* **I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MY DEPENDENTS.**
* **I AGREE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.**

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____ _____
PRINTED NAME **RELATIONSHIP**