

VILLAGE PEDIATRICS

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Contact Information

Child: First Name: _____ Last Name: _____ MI: _____
D.O.B.: ____ / ____ / ____ Sex: _____ Primary Language: _____

Race: Asian / African American / Hawaiian or Pacific Islander / White / American Indian or Alaskan Native / Declined to Answer / Other: _____

Ethnicity: Hispanic / Non-Hispanic / Declined to Answer

Mother/Guardian:

Name: _____

Circle one of the following:

GENETIC, ADOPTIVE, LEGAL GUARDIAN

Date of Birth: ____ / ____ / ____

Address: _____

City: _____ Zip Code: _____

Phone: (____) _____ (Cell, Work)

Lives with patient? Yes / No

Occupation: _____

Employer: _____

Preferred Email: _____

How would this contact ideally prefer to be contacted? Work Phone / Cell Phone

Father/Guardian:

Name: _____

Circle one of the following:

GENETIC, ADOPTIVE, LEGAL GUARDIAN

Date of Birth: ____ / ____ / ____

Address: _____

City: _____ Zip Code: _____

Phone: (____) _____ (Cell, Work)

Lives with patient? Yes / No

Occupation: _____

Employer: _____

Preferred Email: _____

How would this contact ideally prefer to be contacted? Work Phone / Cell Phone

Which Parent will be the Primary Contact: Mother / Father

How did you hear about our office? _____

Emergency Contacts, other than parents: Name & Relationship to **child**

1: _____ Relationship _____ Phone: (____) _____ - _____ (Cell, Work)

2: _____ Relationship _____ Phone: (____) _____ - _____ (Cell, Work)

Preferred Pharmacy: Name: _____ Location: _____

If parents are divorced or separated please fill out this section:

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 / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Do you have other children that come to our office? If yes, please list names and dates of birth.

Child: _____ Date of Birth: ____/____/____
Child: _____ Date of Birth: ____/____/____
Child: _____ Date of Birth: ____/____/____
Child: _____ Date of Birth: ____/____/____

Consent

I am the mother/father of: The Above Named Children give Village Pediatrics permission to treat my child/children should they present themselves in our office when not accompanied by a parent. This consent shall be voided upon written request. **ALSO I UNDERSTAND THAT ULTIMATELY, REGARDLESS OF INSURANCE, I AM RESPONSIBLE FOR ALL CHARGES FOR SERVICES. IF COLLECTION BECOMES NECESSARY, THE UNDERSIGNED SHALL PAY ALL ATTORNEY'S FEES, COSTS AND INTEREST.**

MOTHER OR GUARDIAN

FATHER OR GUARDIAN

DATE: _____

DATE: _____

Acknowledgement for Receipt of Notice Of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices for this practice.

I understand that the practice routinely confirms appointment and reminders about premedication and may leave messages on an answering machine, voicemail, email, post cards, or with another family member.

Witnesses:

Patient or Guardian Signature

Date

Office Staff Witness Signature

Date

FOR OFFICE USE ONLY

Pharmacy phone number verified: (____) _____

Patient-Centered Medical Home Brochure given: ☐