HENDERSONVILLE PEDIATRICS, P.A.

Date ________ Chart # ____________

Please Use Gel Pen or Other Dark (Black) Pen to Complete

PATIENT INFORMATION

Last Name __________________________ First Name ______________________ Middle Initial ______ Sex ____

Date of Birth _____/_____/____________ Preferred Physician ____

Race ____________________ Ethnicity ☐ Hispanic ☐ Non-Hispanic Preferred Language ________________

FAMILY INFORMATION

Parent/Guardian (circle one)

Name____

Mailing Address _________________________________

City ______________________ State _____ Zip _______

Date of Birth ____/____/______ SSN # _____/____/______

Relationship to Patient _____________ (Bio/Step/Other)

Custody ___ Joint ___ Exclusive Marital Status ________

Home Phone_______________ Cell ________________

Email____

Preferred contact method? __ Phone __ Text __ Email

Employer _________________Work Ph._____________

☐ By checking this box, I agree that information for my child can be left on voicemail.

Parent/Guardian (circle one)

Name____

Mailing Address _________________________________

City ______________________ State _____ Zip _______

Date of Birth ____/____/______ SSN # _____/____/______

Relationship to Patient _____________ (Bio/Step/Other)

Custody ___ Joint ___ Exclusive Marital Status ________

Home Phone_______________ Cell ________________

Email____

Prreferred contact method? __ Phone __ Text __ Email

Employer _________________Work Ph._____________

☐ By checking this box, I agree that information for my child can be left on voicemail.

PLEASE LIST ALL CHILDREN UNDER 18 YEARS OLD

1. Childs Full Name ________________________________ Date of Birth ____________________ Bio Sib? (Y/N)
2. Childs Full Name ________________________________ Date of Birth ____________________ Bio Sib? (Y/N)
3. Childs Full Name ________________________________ Date of Birth ____________________ Bio Sib? (Y/N)
4. Childs Full Name ________________________________ Date of Birth ____________________ Bio Sib? (Y/N)
5. Childs Full Name ________________________________ Date of Birth ____________________ Bio Sib? (Y/N)

AUTHORIZED INDIVIDUALS

*Please list all people, **other than parent/guardian,** who may schedule appointments, and what type of information each person is allowed to receive (i.e. grandparents, baby-sitter, neighbor).*

Name ________________________________ Relationship ___________ Phone ________________ ☐ Medical ☐ Billing ☐ Appointment

Name ________________________________ Relationship ___________ Phone ________________ ☐ Medical ☐ Billing ☐ Appointment

INSURANCE INFORMATION

Policy Name ___________________________________ Policy Holder ____________________________________

Employer ______________________________________ Group Number ___________________________________

HP-101-0421 Academy Press

(See Back)

Patient Name:____ **Chart #:**____________________

Authorization to Consent to Health Care for Minor

By signing this statement, I authorize the doctors and staff of Hendersonville Pediatrics, P.A. to provide necessary health services for my child, even if I am not present. Furthermore, the name, relationship to patient, and phone number of all people who may schedule appointments, call for medical advice or bring your child to the office for treatment will be provided to this office. If someone other than these persons contacts us relative to your child, or in the event of a medical emergency, we will attempt to contact the parent or guardian for permission to treat. I authorize Hendersonville Pediatrics, P.A. to release my child's medical records to any party involved in their treatment.

Parent or Legal Guardian Signature Print Name

Financial Policy

I hereby authorize Hendersonville Pediatrics, to furnish medical information to insurance carriers concerning my child/children's illness and treatment. Please present your current insurance ID card at every visit and if anything changes you agree to contact us immediately. Our office makes every reasonable effort to obtain payment according to your coverage. If your insurance company rejects the claim or denies payment our office will bill you for the unpaid portion. All co-payments are to be paid at time of service. I authorize payment of all applicable benefits directly to Hendersonville Pediatrics. This authorization will remain in effect until revoked by me in writing.

Parent or Legal Guardian Signature Print Name

Code of Conduct Policy

Patient and Staff Safety: Our office is committed to the safety of our patients, their families, and our staff. Any verbal abuse, threatening, aggressive, and destructive behavior will not be tolerated. Firearms, including concealed firearms are not permitted within any of our office locations. While we understand that disagreements may occasionally occur, these need to be resolved in a civil manner. Depending on the degree of infraction, we reserve the right to involve Child Protective Services, law enforcement, and other appropriate agencies should we deem it necessary. We may press charges at our discretion.

Parent or Legal Guardian Signature Print Name

Missed Appointment Policy

I acknowledge families missing a total of four appointments without calling or prior notification will result in termination of care from the practice.

Parent or Legal Guardian Signature Print Name