HENDERSONVILLE PEDIATRICS, P.A.

Date _____ Chart # _____

VISITOR FORM

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

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Sex ____

Date of Birth _____/_____/_____ Preferred Language _____ Race _____

Ethnicity ☐ Hispanic ☐ Non-Hispanic Preferred contact method? ____Phone ____Text ____Email

Home Phone _____ Cell Phone _____ Additional Phone _____

Mailing Address _____ City _____ State ____ Zip _____

Primary Care Office Name _____ City _____ State ____Zip_____

Child lives with _____ Relationship to Patient _____ Phone_____

FAMILY INFORMATION

Parent/Guardian (circle one)

Name_____

Mailing Address _____

City _____ State _____ Zip _____

Relationship to Patient _____ Legal Custody (Y/N)

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

Email _____

Parent/Guardian (circle one)

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Relationship to Patient _____ Legal Custody (Y/N)

Date of Birth____/____/_____ SSN#_____/____/_____

Email _____

PATIENT PAST MEDICAL HISTORY

Previous Diagnosis:

_____

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

_____

_____

Are Vaccines up to date? _ _Yes ____No

Do Not Vaccinate_ _

Family Medical History:

Mother: _____

_____

_____

Father: _____

_____

_____

Brother/Sister: _____

_____

_____

INSURANCE INFORMATION

Policy Name _____ Policy Holder _____

Employer _____ Group Number _____

(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

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

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