PEDIATRIC ASSOCIATES
OF MT. CARMEL, INC.

offices in
Eastgate, Batavia, Landen

513-752-3650
pedsmtcarmel.com

Adult Patient Information

Last Name	**First Name**	**Middle Name or Initial**	**Date of Birth** (DOB)	**Social Security Number** (SSN)	**Sex** M/F	**Race**	**Ethnicity** Hispanic/Latino Y or N	**Preferred Language(s)**

If you wish to decline to provide information about race, ethnicity, or language, please leave the box blank

Patient Address _____

City _____ State _____ Zip _____ County _____

Email Address _____ Add Portal Account (if not already established)? **Y** or **N**

Phone Numbers

Primary Phone Number		Type (circle) HOME CELL WORK Relationship to Patient
Secondary Phone Number		Type (circle) HOME CELL WORK Relationship to Patient
Tertiary Phone Number		Type (circle) HOME CELL WORK Relationship to Patient

Patient's Confidential Communication Preference

Method (circle): Cell Phone Work Phone Home Phone Email Text _____

provide phone number or email above

Patient Portal

Once you are 18 years old, parents and guardians no longer have full access to your chart through their portal accounts. Therefore, you **MUST** choose one of the following options*:

☐ Hide my chart from all existing portal accounts

This option allows other adults with current portal access to send and receive messages via the portal on your behalf if you give permission on your Communication Release of Information form, but it would not give them access to your protected medical information.

☐ Remove me from all existing portal accounts other than my own

*This option will limit **all** portal access to everyone other than yourself*

**You may change your preference about portal access for individuals other than yourself if needed*

Emergency Contact (not living in home)

Name _____ Relationship _____ Phone Number _____

Insurance (copy of insurance card to be kept on file)

Name _____ Member # _____ Group # _____

I hereby assign all medical benefits to which the patient is entitled to Pediatric Associates of Mt. Carmel, Inc. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, paid or not paid, by said insurance. I also authorize Pediatric Associates of Mt. Carmel to evaluate and treat any and all medical conditions during this and subsequent visits.

I **DO**/**DO NOT** consent to have the physicians and other staff at Pediatric Associates of Mt. Carmel communicate with me by phone and leave voicemail messages regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I acknowledge I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted in writing to the Practice Manager/Privacy Officer.

Signature _____ Date _____