



New Patient/Transfer Patient Information

Please return to: medrecords@pediatricsservices.org

PATIENT INFORMATION

Patient full name: _____
Patient DOB: _____ Sex/Gender: [M] [F]
Patient address: _____
City: _____ State: _____ Zip code: _____ Primary Language: _____
Patient email (18+): _____ Patient phone (18+): _____
Do you have a sibling who is a patient of Pediatric Services? If yes, Name: _____ DOB: _____

PRIMARY PARENT/GUARDIAN

Name: _____
Address: Check if address is the same as above

City: _____ State: _____ Zip code: _____
Email: _____
Phone (H): _____
(C): _____
 Check if this party is responsible for bills.

SECONDARY PARENT/GUARDIAN

Name: _____
Address: Check if address is the same as above

City: _____ State: _____ Zip code: _____
Email: _____
Phone (H): _____
(C): _____
 Check if this party is responsible for bills.

PRIMARY INSURANCE INFORMATION

Insurance company: _____ Policy #: _____ Group #: _____
Policy holder name: _____ Policy holder DOB: _____

SECONDARY INSURANCE INFORMATION

Insurance company: _____ Policy #: _____ Group #: _____
Policy holder name: _____ Policy holder DOB: _____

FINANCIAL OBLIGATION

I understand all insurance co-pays are due at the time of service.

I understand it is my financial responsibility for all services rendered that are not covered/paid for by primary/secondary insurance.

I understand and agree to the late/no show policy. I understand I am subject to a late/no show service charge of \$25.00. Details about the late/no show policy may be found on www.pediatricsservices.org.

Signature of financially responsible parent/guardian: _____ Date: _____

Pediatric Services of Springfield Vaccination Policy

At Pediatric Services of Springfield, we provide safe, evidence-based care for all children. Immunizations are a vital part of preventive pediatric healthcare and help protect individual patients and our broader community, including newborns, infants, and immunocompromised individuals.

Please review this policy carefully. We are happy to discuss any questions prior to establishing care.

Our Policy

- Our practice follows the American Academy of Pediatrics (AAP) recommended immunization schedule.
- All patients are required to receive routine childhood vaccinations according to this schedule.
- Families who delay, selectively vaccinate, or decline vaccinations are not compatible with our practice model.
- No non-medical exemptions are accepted.
- Medical exemptions are granted only when clinically indicated and must be determined by the patient's healthcare provider.
- Continued care at our practice requires adherence to this vaccination policy.
- Families who choose to stop vaccinating, delay future vaccines or selectively vaccinate after establishing care will be required to transition to another pediatric provider.

Acknowledgment

By signing below, I acknowledge that I have read and understand Pediatric Services of Springfield's Vaccination Policy and agree to comply with it. I understand that this practice requires patients to receive all routinely recommended childhood vaccinations per the AAP schedule unless a medical exemption is determined by the patient's healthcare provider. I understand that failure to comply with this policy while an active patient may result in dismissal from the practice, in accordance with applicable state regulations and notice requirements.

Child's Name: _____

Date of Birth: _____

Parent/Legal Guardian (Printed): _____

Signature: _____

Date: _____