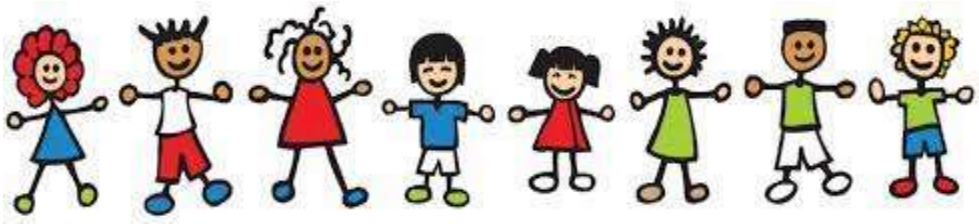

Pediatric Care Center

Patient information Form

First Name: Middle: Last:

Preferred name (if different): _____

Address: _____ APT/Unit #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Patient SSN#: _____

Gender: _____ Race/Ethnicity: _____

Primary Insurance

Primary Insurance: _____ Policy #: _____

Policy holder: _____ Policy holder date of birth: _____

Relationship: _____ Employer: _____

SSN#: _____

Cash Payor: _____

Secondary Insurance

Primary Insurance: _____ Policy #: _____

Policy holder: _____ Policy holder date of birth: _____

Relationship: _____ Employer: _____

SSN#: _____

Parent/Guardian Information

Mother's Information

First Name: _____ Maiden: _____ Last: _____

Address: APT/Unit #:

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Date of Birth: _____ SSN#: _____

Financially responsibility: _____

Father's Information

First Name: _____ Middle: _____ Last: _____

Address:_____ APT/Unit #: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Date of Birth: _____ SSN#: _____

Financially responsibility: _____

Legal Guardian Information

First Name: _____ Middle: _____ Last: _____

Address:_____ APT/Unit #: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Date of Birth: _____ SSN#: _____

Financially responsibility: _____Do you have Legal paperwork: _____

Does the child live with both parents? _____

If not, who does the child live with? _____

Medical History

Current Medications: _____

_____

_____

_____

Current Medical Conditions:_____

_____

_____

_____

Allergies (medications, food, environmental): _____

_____

_____

_____

Chronic Conditions (ex. asthma, diabetes, etc.) : _____

_____

_____

_____

Past Surgeries or Hospitalizations:

Any other concerns about your child we need to be aware of: _____

_____

_____

_____

Consent & Acknowledgements

Initial the following

_____I authorize the release of medical records necessary to process insurance claims.

_____ I consent to treatment and/or testing for the minor child.

_____ I acknowledge that after **2 no-shows** for appointments, I will be **charged** a no-show fee of **$25.00**, for each no-show appointment in the future. The fee will be due and payable before any future appointments can be made. This is for **CASH PAY/PRIVATE INSURANCE PATIENTS.**

_____ For **MEDICAID** patients, after **THREE (3)** no-show appointments in a **SIX (6)** month period **Medicaid will be notified**.

_____ Less than 24 hours' notice for cancellation will count as a missed appointment.

_____ I acknowledge that any balance owed after insurance pays is due and payable within 45 days of the insurance payment.

_____ I agree if the balance cannot be paid in full, I will set up a monthly payment plan until such balance is satisfied.

Responsible party's signature: _____
(Parent/Guardian)

Date: _____

Authorization and Consent to Release Medical Records/Medical & Health Information

As the parent/guardian of the minor child I authorized the following individual(s) to obtain medical records, Medical & Health Information, and to obtain medical treatment from this facility.

	Obtain Medical Records	Medical/Health Info.	Obtain Treatment
	PLEASE CHECK THE APPROIATE BOX(es)		
Name: _____ Relationship: _____ Phone #: _____	☐	☐	☐
Name: _____ Relationship: _____ Phone #: _____	☐	☐	☐
Name: _____ Relationship: _____ Phone #: _____	☐	☐	☐
Name: _____ Relationship: _____ Phone #: _____	☐	☐	☐

Parent/Legal Guardian: _____

Date: _____