JUST KIDS PEDIATRICS
PATIENT/FAMILY INFORMATION FORM

PATIENT'S FULL NAME: _____ **BIRTH DATE**: _____/_____/_____

Sex: ___M ___F **Race** (check all that apply): ___Native American ___Asian ___Black ___White ___Hawaiian

Primary Language: ___English ___Spanish _____List Other **Ethnicity**: ___Hispanic ___Non-Hispanic ___Unknown

PRIMARY CARE PHYSICIAN: **____ Kerry Kirifides, MD** **____ Sonia Shastry, DO** **____ Madison Goudy, PA-C**
(Please check one) **____ Kimberly Ferguson, PA-C** **____ Jaclyn Liguori, PNP**

PRIMARY CONTACT PERSON:

Check One: ___Biological Mother ___Step-Mother ___Adoptive Mother ___Foster Mother ___Legal Guardian Other: _____
___Biological Father ___Step Father ___Adoptive Father ___Foster Father ___Legal Guardian Other: _____

Name: _____ Birth Date: _____/_____/_____ Home Phone: _____

Address: _____ Work Phone: _____ Cell Phone: _____

City: _____State: _____ Zip: _____ Primary Contact: ____Home ____Cell

Email Address (unique)_____

May this contact have patient portal access for this child? ____Yes ____No Do you live with the patient? ____Yes ____No

Please choose (1) method of contact for recall messages: ____Home ____Cell ____Text ____ Email
Please choose (1) method of contact for portal messages: ____ Text ____Email
Please choose (1) method of contact for appointment reminders: ____Home ____Cell ____Work

SECONDARY CONTACT PERSON:

Check One: ___Biological Mother ___Step-Mother ___Adoptive Mother ___Foster Mother ___Legal Guardian Other: _____
___Biological Father ___Step Father ___Adoptive Father ___Foster Father ___Legal Guardian Other: _____

Name: _____ Birth Date: _____/_____/_____ Home Phone: _____

Address: _____ Work Phone: _____ Cell Phone: _____

City: _____State: _____ Zip: _____ Primary Contact: ____Home ____Cell

Email Address (unique)_____

May this contact have patient portal access for this child? ____Yes ____No Do you live with the patient? ____Yes ____No

Please choose (1) method of contact for recall messages: ____Home ____Cell ____Text ____Email
Please choose (1) method of contact for portal messages: ____Text ____Email
Please choose (1) method of contact for appointment reminders: ____Home ____Cell ____Work

Who has PRIMARY PHYSICAL CUSTODY (if applicable)? _____

Who is the **Financial Guarantor** (person receiving billing statements)? _____

In order to fulfill new legal requirements and to obtain more accurate Family Medical History requirements, we now require BOTH BIOLOGICAL PARENTS to be listed (if contacts listed above are NOT the BIOLOGICAL PARENTS):

Biological Mother: _____ (if known) Birth Date: ____/____/____ No parental rights per court order _____

Biological Father: _____ (if known) Birth Date: ____/____/____ No parental rights per court order _____

JUST KIDS PEDIATRICS
PATIENT/FAMILY INFORMATION FORM

PATIENT'S FULL NAME: _____ **BIRTH DATE**: _____/_____/_____

PRIMARY INSURANCE:

Name of Insurance Company: _____ Member ID #:_____

Who carries the insurance? _____ Date of Birth: ____/____/____ SS#: _____-____-_____

Relationship to patient: _____ Phone: _____ Do you live with patient? ____Yes ____No

SECONDARY INSURANCE:

Name of Insurance Company: _____ Member ID #: _____

Who carries the insurance? _____ Date of Birth: ____/____/____ SS#: _____-____-_____

Relationship to patient: _____ Phone: _____ Do you live with patient? ____Yes ____No

STATEMENTS:

How would you like to receive billing statements? ___ Notify Via Patient Portal ___ Mail

PREFERRED PHARMACY:

Pharmacy Name: _____ Pharmacy Phone Number: _____

I have reviewed copies of the **Financial Policy** and **Notice of Privacy**, and these notices are available in the office and on Just Kids Pediatrics website. Copies are available upon request. I understand both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. I understand if there are Custody Orders in place, I must present current copies for my child's file. I authorize the people listed to bring my child to any appointments in my absence and Just Kids Pediatrics may call and leave a message regarding my child's clinical care, including lab and x-ray results in my absence. I understand this authorization for release of information will remain in effect until parent or guardian changes their disclosure with Just Kids Pediatrics in writing. At that time this authorization will expire. I authorize Just Kids Pediatrics, only upon my request, to fax any forms or immunization records to my child's school. I authorize Just Kids Pediatrics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners. I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Just Kids Pediatrics. I understand that I am personally responsible for being aware of the dates and times of my child's scheduled appointments and that there is a fee for any missed appointment not cancelled within 24 hours of the scheduled appointment.

Signature _____ Relationship to Patient _____ Date _____