

All Star Pediatrics – Patient/Family Information Form

	First Child	Second Child	Third Child	Fourth Child
First Name				
Middle Initial				
Last Name				
Sex (M/F)				
Date of Birth				
Primary Language Spoken (If not English)				
Ethnicity	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Choose not to Answer	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Choose not to Answer	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Choose not to Answer	☐ Not Hispanic ☐ Hispanic ☐ Unknown ☐ Choose not to Answer
Race (Check all that apply)	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Choose not to Answer	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Choose not to Answer	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Choose not to Answer	☐ Native American ☐ Black ☐ Asian ☐ White ☐ Pacific Islander ☐ Choose not to Answer

Residence Address: _____ Primary Phone: (_____) _____ - _____
Primary Phone for child/children may be a "home" phone or a cell phone.

Does this Residence Address and Primary Phone apply to all children shown? **Yes** **No** (Circle one. If No, please ask for assistance.)

Primary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: ____/____/____
 Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

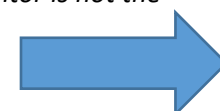
Secondary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: ____/____/____
 Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

* **Who is the Policy holder for Insurance?** _____

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

(Financial Guarantor must be included in Contacts on page 2. If the guarantor is not the same for all children, please ask for assistance)



Contacts

	First Contact (Parent/Guardian)	Second Contact (Parent/Guardian)
Full Name		
SSN- last four digits only		
Relationship to Patient(s)?		
Resides with Patient(s)?		
Street Address		
Address: City, State, Zip		
Birth Date		
Primary Phone: ("Home" phone)		
Work Phone:		
Cell Phone:		
Email: Must be unique to Contact		
Contact may have access to Patient Portal for all children? (Yes or No)		
Preferred method of Contact for Portal Messages (Circle one)	I do not want to be contacted about portal messages Text to Cell Home E Mail	I do not want to be contacted about portal messages Text to Cell Home E Mail

- If Patient is 18 or older, Include Contact Info for Patient. Please use another form if more Contact space is needed.

Emergency Contact for listed children (other than Contacts listed above. If this person is also an authorized representative – please also list below):

Name _____ Relationship to Patient(s) _____ Phone (____) ____ - _____

Please list anyone else authorized to be your representative and bring your child(ren) to appointments:

I understand I can change or revoke the below authorization at any time but I can't change or revoke names given by another parent.

Name _____ Relationship to Patient(s) _____ Phone (____) ____ - _____

Name _____ Relationship to Patient(s) _____ Phone (____) ____ - _____

I acknowledge that the **Financial Policy** and **Notice of Privacy Practices**, are available in the office and on our 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 All Star 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 All Star Pediatrics in writing. At that time this authorization will expire. I authorize All Star Pediatrics, only upon my request, to fax any forms or immunizations records to my child's school. I authorize the doctor 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 All Star Pediatrics. I understand All Star Pediatrics provides immunization information to the Pennsylvania State Immunization Information System, and I may opt out of having my child's information sent by notifying All Star in writing. I understand that I am personally responsible for being aware of the dates and times of my scheduled appointments.

Signature _____ Relationship to Patient(s) _____ Date _____