CUMBERLAND
PEDIATRIC • ASSOCIATES

PATIENT INFORMATION

Name of Patient: _____
First Middle Last

*please check each item below for required insurance reporting:

Ethnicity: ☐ Hispanic/Latino ☐ non-Hispanic ☐ unknown ☐ decline to answer **Preferred language**:_____

Race: ☐ white ☐ black/African-American ☐ American Indian ☐ Pacific Islander ☐ other ☐ decline to answer

Address: _____City: _____ State: ____ Zip: _____

Date of Birth: _____ Social Security#: _____

Home Phone: _____ Email: _____

PARENT INFORMATION

Mother's Full Name: _____ Mother's Date of Birth _____

Mother's Social Security #: _____ Mother's Cell #_____

Father's Full Name: _____ Father's Date of Birth _____

Fathers' Social Security #: _____ Father's Cell # _____

Child lives with: ❑ Mother ❑ Father

Please list all siblings: _____

_____

ADDITIONAL INFORMATION

How would you like us to contact you? Primary phone (**H**) Mom cell (**C**) Father cell (**T**) preferred email (**E**)

Emergency Contact: _____ Relationship: _____ Phone/Cell #: _____

Do you give permission for another person (besides those listed as mother and father) to bring your child to the doctor? ☐Yes ☐No
If anyone other than a parent may bring your child, please list.

_____

_____

Your Relationship to Patient: _____ (Only a natural parent or someone who has legal custody with paperwork to show proof may complete paperwork)

Your Signature: _____ Date: _____

INSURANCE & BILLING INFORMATION

Primary Insurance: _____ Insurance ID: _____Group #: _____

Subscriber/Relationship: _____ Date of Birth: _____

Secondary Insurance: _____ Insurance ID: _____Group #: _____

Subscriber/Relationship: _____ Date of Birth: _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT, & RELEASE OF RECORDS

(Please initial each statement indicating that you are in agreement.)

_____I agree to permit authorized personnel of *Cumberland Pediatric Associates, PC* to perform routine medical treatment, examinations, laboratory tests, and emergency procedures as deemed necessary by the providers in this office.

_____I hereby assign my insurance benefits to be paid directly to Cumberland Pediatric Associates. I also authorize the providers and his/her designee to release my information acquired in the course of my examination and treatment necessary to process claims and/or coordinate care with other health practitioners.

_____I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that if my account becomes delinquent, my account could be referred to an outside collection agency. If this happens, I would be responsible for all court costs, attorney's fees and collection costs (33%) associated with recovering my account.

_____I am aware the practice's **"Notice of Privacy Practices"** is always available in waiting areas and on the practice website and have been offered a copy of the practice's Notice of Privacy Practices.

_____I am aware of the practice's **'Financial & Managed Care Policy Statement"** is always available in waiting areas and on the practice website and agree to the practice's Financial & Managed Care Policy.

_____I am aware and agree to the practice's **Vaccination Policy**. I am aware that this policy is posted in the waiting rooms and on the practice's website.

I agree that this authorization is valid regardless of when I receive services at this office and that I am the patient or authorized to sign this document.

_____ _____

Patient or Authorized Party Signature ***Date***