PEDIATRICS 5280 PATIENT INFORMATION

All information must be completed Today's Date__________________

Circle One: Dr. Bosley Dr. Bouzarelos Dr. Dacey Dr. Deckerman Dr. Jones-Bamman Dr. Middlemist
Dr. Parra Dr. Tiehen Dr. Traver Dr. Wallendal Dr. Young Mary Kop, PA-C

Mother of Child ____ SS#_______________
Last First Middle Int.

Address ____ DOB ____/____/____
Street City State Zip

Phone (home)________________________ (work)________________ (cell)__________________ (email)____________________

Mother's Employer__________________________________ Position_____________________ Length of time at Job __________

Father of Child ____ SS#_______________
Last First Middle Int.

Address ____ DOB: ____/____/____
Street City State Zip

Phone (home) __________________ (work)_____________________ (cell)__________________ (email)____________________

Father's Employer __________________________________ Position_____________________ Length of time at Job __________

Referred by____________________________________ Child(ren) live with ____________________________

Emergency Contact (other than Parent)_________________________________ Phone________________ Relationship ___________

Insurance Name and Policy ____________________________ Financially Responsible Party ______________________________

Full Names of All Children, oldest to youngest. ***Please mark the box of children that will be patients at Pediatrics 5280.***

	First Name	Middle	Last Name	Birthdate	M/F	Age	Cell Phone #
□							
□							
□							
□							
□							

I have been provided information regarding immunizations: DTaP, DT, Td, Tdap, POLIO, MMR, HIB, HEPATITIS B, CHICKEN POX, HEPATITIS A, MENINGOCOCCUS, PNEUMOCOCCUS, HPV, ROTAVIRUS, and INFLUENZA. I authorize the release of Newborn Genetic screening information to Pediatrics 5280. I assign directly to Pediatrics 5280 all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred, whether or not paid by insurance. I hereby authorize Pediatrics 5280 to release all information necessary for claims administration and evaluation, utilization review and financial audit. I authorize Pediatrics 5280 to give my child reasonable and proper care by today's standards. I authorize my child to be treated without my being in attendance. I acknowledge that I have received Pediatrics 5280's Notice of Privacy Practices. I authorize Pediatrics 5280 to call my cellphone or residential phone by autodialer.

Signature____ Date_________________

Over 18 years Patient Sign____ Date_________________