

PEDIATRICS 5280 PATIENT INFORMATION

All information must be completed

Today's Date \_\_\_\_\_

Circle One: Dr. Bouzarelos Dr. Dacey Dr. Deckerman Dr. Jones-Bamman Dr. Middlemist Dr. Parra Dr. Swant  
Dr. Tiehen Dr. Traver Dr. Wallendal Dr. Young Mary Kop, PA-C Leslie Will, PA-C Caroline Hopper, PA-C

Parent/Guardian of Child \_\_\_\_\_  
Last First Middle Int.

Address \_\_\_\_\_  
Street City State Zip DOB: \_\_\_/\_\_\_/\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_ (email) \_\_\_\_\_

Parent/Guardian of Child \_\_\_\_\_  
Last First Middle Int.

Address \_\_\_\_\_  
Street City State Zip DOB: \_\_\_/\_\_\_/\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_ (email) \_\_\_\_\_

Step Parent(s) \_\_\_\_\_ Phone number(s) \_\_\_\_\_

Referred by \_\_\_\_\_ Child(ren) live with \_\_\_\_\_

Emergency Contact (other than Parent) \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

INS Holder Name \_\_\_\_\_ DOB and SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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.

<u>First Name</u>	<u>Middle</u>	<u>Last Name</u>	<u>Birthdate M/F</u>	<u>Age</u>	<u>Cell Phone #</u>
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

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 \_\_\_\_\_