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. Puccio

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 _____ DOB ____/____/____
Street City State Zip

Phone (home)_____ (work)_____(cell)_____ (email)_____

Parent/Guardian of Child_____
Last First Middle Int.

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

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.***

	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_____