



PATIENT DATA

The "Family Form" can be used if all children in the family have the same information. If not, i.e. foster care, blended family, or separation/divorce, please complete individual forms for each child.

FOR THE FAMILY FORM - PLEASE LIST EACH CHILD IN FAMILY BELOW

Office Use	Last Name	First Name	Middle Initial	Date of Birth	Gender	Child Resides With
<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both

Financially Responsible Party _____

Mailing/Billing Address _____

City _____ State _____ Zip _____

TELEPHONE NUMBERS

- Primary phone (#1) is the one to be used for messages and reminder calls; does not have to be the home phone.
- Please list phone numbers in order to be called.

1 ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: _____
2 ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: _____
3 ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: _____
4 ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: _____
5 ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other: _____

PARENT / GUARDIAN INFORMATION

Mother's Name _____ DOB ____/____/____

Single Married Divorced Widowed

Physical Address (if different from above) _____

E-Mail Address _____ Social Security # _____

Employer/Occupation _____ Phone Number _____

Father's Name _____ DOB ____/____/____

Single Married Divorced Widowed

Physical Address (if different from above) _____

E-Mail Address _____ Social Security # _____

Employer/Occupation _____ Phone Number _____

Custodial parent, if applicable _____

Step parent's names, if applicable _____

MISCELLANEOUS DATA

Emergency Contact (other than above) _____ Phone _____

Former Pediatrician (if applicable) _____ Referred by _____

PLEASE FILL IN ALL SECTIONS COMPLETELY

Family Last Name _____

INSURANCE DATA

Effective Date _____

Insurance Co. Name _____

Insurance Claim Address _____

_____ City _____ State _____ Zip _____

Insurance Phone Number _____

Policy Holder Name (Guarantor) _____

Policy Holder (Guarantor) Social Security # _____ - _____ - _____ Policy Holder DOB ____ / ____ / ____

Insurance ID # _____

Group # _____

CONSENT FOR PAYMENT / ASSIGNMENT OF INSURANCE BENEFITS / PRIVACY POLICY

CONSENT FOR PAYMENT

I understand that I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed.

Initial _____ I understand that **Insurance/Medicaid Cards should be presented at EVERY VISIT.**

I hereby authorize direct payment of surgical/medical benefits to **Parker Pediatrics and Adolescents, P.C.**, for service rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize **Parker Pediatrics and Adolescents, P.C.** to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.

Initial _____ Divorce has no bearing on the responsibility for medical care as it affects third parties. **WHOEVER BRINGS THE CHILD IS EXPECTED TO PAY THE CHARGES DUE FOR THE SERVICE RENDERED THAT DAY.** Parker Pediatrics & Adolescents does not participate in payment disputes between parents.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received, or have been given the opportunity to receive, a copy of the **HIPAA Notice of Privacy Practices for Parker Pediatrics & Adolescents, P.C.**

Initial _____

E-MAIL PERMISSION

I **DO** wish to be included in the Parker Pediatrics e-mail list to receive occasional brief announcements and timely information. (**Strongly recommended in order to receive flu clinic dates, local epidemics / infection reports, office policy changes, and the link to our newsletter.**)

- I understand that I may opt out at any time.
- I understand that this information is NOT shared with third parties and is for the exclusive use of Parker Pediatrics.

I **DO NOT** wish to be included in the Parker Pediatrics e-mail list.

The above information is current and correct.

Parent/Guardian Signature _____ Date _____