South County Pediatric Associates

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Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Child 4: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____

Insurance Carrier: _____ Policy ID#: _____

Group #:_____ Gender: Male/Female

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____-_____-_____

Insurance Carrier: _____ Policy ID#: _____

Group #:_____ Gender: Male/Female

Name and Address of Financially Responsible Parent/Guardian:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

Pharmacy Information

Preferred Pharmacy:_____ **Phone Number**:_____

Contact Information

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number:_____

Is this a cell phone? Yes / No and their Address:

Relation to Patient: _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number: _____

Is this a cell phone? Yes / No and their Address: _____

Relation to Patient: _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____

2: _____ Relationship _____ Phone: (___) _____ - _____

Additional Contact Questions:

May all contacts have access to the patient's records electronically? Yes / No

If no, list who may have access:

_____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Consent for Treatment in My Absence: I hereby give South County Pediatrics Associates advance consent to any medical procedure for the above named child(ren) in the event that I am unable to accompany him or her to the office and he or she is accompanied by one of the following:

1: _____ Relationship _____ Phone: (___) _____ - _____

2: _____ Relationship _____ Phone: (___) _____ - _____

Signature of Parent/Guardian:_____ **Date**: _____

Consent to Treat: I hereby give South County Pediatrics Associates or their designee authority to administer treatment to the above named child(ren).

Signature of Parent/Guardian:_____ **Date**: _____

Financial Responsibility: I hereby assign all medical and/or surgical benefits to which I am entitled through private insurance for my dependents to South County Pediatrics Associates. I understand that I am responsible for the charges incurred with my child's care. In the event that insurance fails to cover these charges, I understand that I am responsible for all charges. I will be responsible for collection costs and attorney fees associated with the cost of resolving my account. I also consent to release of any information to my insurance company or their designated representatives for claims processing or any other purpose for which they may request copies of medical records. This release will remain valid unless I revoke it in writing to South County Pediatrics.

Signature of Parent/Guardian:_____ **Date**: _____

*Paperwork Completed by: _____ Date: _____