PATIENT INFORMATION

Child 1: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Child 2: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Child 3: First Name: _____ **Middle Name:** _____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name and Relationship): _____
Relationship to *Mother/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____
Relationship to *Father/Guardian* listed below ☐ **Biological Child** ☐ **Step Child** ☐ **Adoptive Child** ☐ **Foster Child** ☐ **Other:** _____

Preferred Pharmacy: _____ **Pharmacy Location:** _____

Insurance Information:

Primary Policy
Insurance Carrier: _____ Insurance ID #: _____ Group #: _____
Name of Policy Holder: _____ DOB of Policy Holder: _____

Secondary Policy
Insurance Carrier: _____ Insurance ID #: _____ Group #: _____
Name of Policy Holder: _____ DOB of Policy Holder: _____

Mother/Guardian Info

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **DOB:** _____

Employer/Occupation: _____ **SSN:** _____

Cell Phone: _____ **Home Phone:** _____

Home Address: _____

E-mail: _____ **Authorized to have access to patient's records electronically?** ☐ **Yes** ☐ **No**
What is your preferred method of contact for appointment reminders? Cell Phone / Home Phone/ E-mail

Father/Guardian Info

First Name: _____ **Middle Name:**_____ **Last Name:** _____ **DOB:** _____

Employer/Occupation: _____ **SSN:** _____

Cell Phone: _____ **Home Phone:** _____

Home Address: _____

E-mail: _____ **Authorized to have access to patient's records electronically?** ☐ **Yes** ☐ **No**
What is your preferred method of contact for appointment reminders? Cell Phone / Home Phone/ E-mail

Continued on Back

Responsible Party Information: The responsible party is the person that will be receiving the billing statements. This person is also financially responsible for the patient's medical bills. Copays and balance payments are expected at time of service, regardless of custodial agreements.

First Name: _____ Middle Name:_____ Last Name: _____ DOB: _____

Home Address: _____
Street City State Zip Code

Phone Number: _____ Relationship to Patient: _____

Alternate Contact Information: Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. Indicated below are the names of any person(s) to whom you allow disclosure of health information related to your child and authorize to oversee patient care.

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____

Phone Number: _____ Relationship to Patient: _____

Notify In Case Of Emergency (Not A Parent/Guardian)

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Separated/Divorced Families

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.

_____

Authorization of Treatment and Assignment of Benefits

I authorize Northwest Pediatrics Inc., to treat my child. I have been presented with a copy of the Notice of Privacy Practice detailing how my child's health information may be used and disclosed as permitted under the federal and state law and outlining my rights regarding my child's health information. I also acknowledge that I have been presented with a copy of Northwest Pediatrics Office Policies.

Signature of Parent or Legal Guardian_____

Relationship to Child_____ Date_____

Person Completing Form

Printed Name: _____ Signature: _____ Date: _____