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Demographics

Today's Date: ____________________

Patient's Last Name: ____________________

Patient's First Name: ____________________

Preferred Name: ____________________

DOB: ____________________

Gender: ☐ Male ☐ Female

Primary Provider: (check one)

☐ McCray ☐ Jacobson ☐ Anguiano

Ethnicity: (check one)

☐ Unknown ☐ Hispanic or Latino

☐ Not Hispanic or Latino ☐ Declined

Race(s): (check one)

☐ American Indian or Alaskan Native ☐ Asian

☐ Black ☐ Hawaiian or Pacific Islander

☐ White ☐ Declined to Answer

Preferred Language: ____________________

Patient Confidential Communication Preference:

☐ No Preference

Contact Name: ____________________

Method:

☐ Address: ____________________

____

City: __________ State: ______ Zip: ______

☐ Email: ____________________

☐ Phone: ____________________ ☐ Cell ☐ Text ☐ Home ☐ Work

Other Children in Family:

Name: ____________________ DOB ________

Name: ____________________ DOB ________

Name: ____________________ DOB ________

Name: ____________________ DOB ________

Patient Lives With:

First Name(s): ____________________

Last Name(s): ____________________

Address: ____________________

City: __________ State: Zip: ________

Home Phone: ____________________ ☐ Mom ☐ Dad ☐ Other

Cell 1 Phone: ____________________ ☐ Mom ☐ Dad ☐ Other

Cell 2 Phone: ____________________ ☐ Mom ☐ Dad ☐ Other

Other

Phone__________________Relationship:__________

Email: ____________________

Bills Sent To: ☐ Same as Above

First Name: ____________________

Last Name: ____________________

Address: ____________________

City: __________ State: Zip: ________

Home Phone: ____________________ ☐ Mom ☐ Dad ☐ Other

Cell 1 Phone: ____________________ ☐ Mom ☐ Dad ☐ Other

Cell 2 Other: ____________________ ☐ Mom ☐ Dad

Relationship:______________________________

Email: ____________________

Insurance Information:

Primary Insurance: ____________________

Subscriber: ____________________

Sex: ☐ Male ☐ Female DOB: ____________

Subscriber ID: ____________________

Group Number: ____________________

Secondary Insurance: ____________________

Subscriber: ____________________

Sex: ☐ Male ☐ Female DOB: ____________

Subscriber ID: ____________________

Group Number: ____________________

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Acknowledgement of Privacy Practices:

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Responsible Party

____

Date

Except for life threatening emergencies, we are not able to treat your minor child unless he or she is accompanied to our office by a parent, legal guardian or designated adult. In order to designate an adult to bring your child into our office for medical care in your absence, you must have the following form completed, signed, and on file for each designated adult for each of your children. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form

Alternate Caregiver Consent Form

I authorize the following individual(s) to bring in my children to their appointments:

Name: ______________________ Relationship to child: ______________

Name: ______________________ Relationship to child: ______________

Name: ______________________ Relationship to child: ______________

I attest that the above named individual(s) are all 18 years of age or older as of this date. I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures and hospitalizations. This practice may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary.

I agree to hold Through the Years Pediatrics and its staff harmless for any disagreement between the above named individual(s) and myself regarding treatment decisions.

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I attest that I am the parent or legal guardian of the above named children and that I have legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

____

Signature of Parent/legal guardian

____

Date Name of parent/legal guardian (print) Phone contact for parent/legal guardian

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and any other medical/health plan, to issue payment check(s) to Through the Years Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Through the Years Pediatrics to release any information necessary to insurance carriers regarding my illness and treatments, process insurance claims generated in the course of examination or treatment, and allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Through the Years Pediatrics on behalf of myself and/or dependents, and understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____

Printed Name(s) of the Patient

____

Signature of Patient or Responsible Party if a Minor