Please complete all parts of this form. All requested information is important.

A·B·C Pediatrics
Adolescents · Babies · Children
"Building a Brighter Future through Better Health"

Chart #: _____

PATIENT

Patient's Information

Full Name: _____ Social Security #: _____

Sex: ❑Male ❑Female Birthdate: _____ Race: _____ Goes By: _____
(Required for Medical Purposes Only)

Street Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Person financially responsible: _____ **PRIMARY Phone:** ( ) _____

MOTHER

Parents' Information

Mother's Full Name: _____ Social Security #: _____

Birthdate: _____ **Marital Status:** ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
(for proper identification purposes)

Full Mailing Address: _____

City: _____ State: _____ Zip: _____ **E-Mail Address:** _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Cell Ph: ( ) _____ **Would you like texts from us?** ❑Yes ❑No

Employer: _____ Work Ph: ( ) _____

FATHER

Father's Full Name: _____ Social Security #: _____

Birthdate: _____ **Marital Status:** ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
(for proper identification purposes)

Full Mailing Address: _____

City: _____ State: _____ Zip: _____ **E-Mail Address:** _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Cell Ph: ( ) _____ **Would you like texts from us?** ❑Yes ❑No

Employer: _____ Work Ph: ( ) _____

Emergency Contact

(Who may we contact regarding the patient if we are unable to reach a parent?)

Name: _____ Relationship to Patient: _____

Birthdate: _____ (for proper identification purposes)

Home Ph: ( ) _____ Cell Ph: ( ) _____ Work Ph: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

❑ Please check this box if you do not want ABC Pediatrics to leave messages on your home/cell voice mail regarding your child's appointments, prescription availability, etc..

Insurance Information

Primary:
Insurance Holder's Full Name: _____ ID #: _____

Insurance Company Name: _____ Group #: _____

Secondary:
Insurance Holder's Full Name: _____ ID #: _____

Insurance Company Name: _____ Group #: _____

Your insurance is a method for you to receive reimbursement for fees you have paid to the provider for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance and/or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Persons Authorized to Request Medical Treatment for Child

In accordance with Privacy Rules set forth by the federal government's Health Insurance Portability and Accountability Act (HIPAA), ABC Pediatrics may disclose your child's protected health information only within specific guidelines. If your child's grandparent, a babysitter/ caretaker, or a friend may be bringing your child to our office for medical treatment, you, as the parent/guardian/personal representative, must give your authorization for ABC Pediatrics to release medical information to that person. Therefore, please indicate below the names (and relationship to child) of individuals to whom ABC Pediatrics may discuss your child's medical information. If anyone other than the parent/guardian/personal representative, or those individuals listed below, brings the child in for care, HIPAA, by law, allows ABC Pediatrics to assume that this individual is authorized to receive health information about your child and we will release only the minimum amount of information needed to enable that individual to appropriately care for the child and to relay the information to the parent.

1. _____ (Authorized Person) _____ (Relationship to Child)
2. _____ (Authorized Person) _____ (Relationship to Child)
3. _____ (Authorized Person) _____ (Relationship to Child)
4. _____ (Authorized Person) _____ (Relationship to Child)

Primary/Secondary Pharmacy

Primary/First Choice **Secondary/Afterhours**

_____

Phone # Phone #

The above-listed child is in my legal custody and I agree to be responsible for all charges incurred in connection with medical care provided to my child.

Printed Name: _____ Relationship to child: _____

Signature: _____ **Date:** _____

Revised 2018