



PATIENT INFORMATION / DEMOGRAPHICS

Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Male Female

Patient's PCP (check one): Dr. Craig Dr. Chait Dr. Antony
 Dr. Stathopoulos Dr. NG

Ethnicity: Hispanic or Latino Not Hispanic or Latino Prefer not to Answer

Race: American Indian/AK Native Asian Black or African American
 Native HI / Pacific IS White
 Prefer not to Answer

The language I prefer to communicate in about my child's care is:
 English Spanish Other _____

*We ask this information as part of our Medical Home Model

PATIENT INFORMATION / DEMOGRAPHICS Check all that apply Mom Dad Other: _____

Mom's First Name: _____ Last Name: _____ DOB _____

Dad's First Name: _____ Last Name: _____ DOB _____

Guardian's First Name _____ Last Name: _____ DOB _____

Address : _____

City: _____ State: _____ Zip: _____

Email _____

Address: _____

Please list all phone numbers that apply:

Home Phone: _____

Mom's Cell Phone: _____ Mom's Work Phone: _____

Dad's Cell Phone: _____ Dad's Work Phone: _____

Preferred number for evening reminder calls:

Home Mom's cell Dad's cell

GUARANTOR / INSURANCE INFORMATION

First Name: _____ Last Name: _____

Address: _____

Phone #: _____ Date of Birth: _____

Patient's Relationship to Insured: Son Daughter Other _____

Insurance Carrier Name: _____

Policy / ID Number: _____ Group Number: _____

Effective Date: _____ Employer: _____

EMERGENCY CONTACT: (in the event the parent(s) cannot be reached)

Contact Name: _____ Relationship: _____ Phone: _____

CONSENT

Consent to release:

I hereby authorize the physicians of this practice to release any and all medical information to the above name insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until it is revoked in writing. I have read this authorization and understand it.

Consent to assignment:

I hereby assign payment of medical services to this practice to which I am entitled or have incurred for medical and/or surgical expense relative to services rendered here. I understand I am financially responsible to said group for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

Consent to treat:

I authorize this practice to provide medical care to my child and authorize treatment or care in my absence if my child is accompanied by the following care giver (check all that apply):

- | | | |
|--------------------------|------------------------|----------------|
| <input type="checkbox"/> | Grandparent(s)/Sibling | Name(s): _____ |
| <input type="checkbox"/> | Nanny/Babysitter | Name(s): _____ |
| <input type="checkbox"/> | Other _____ | Name(s): _____ |

PLEASE NOTE: Unless accompanied by a note from a guardian, vaccinations will not be administered to minors.

Signature of Parent/Legal Guardian: _____

Date: _____