

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



Chart #: _____

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Patient's Information

Full Name: _____ Social Security #: _____
Sex: M F Birthdate: _____ Race: _____ Goes By: _____
(Required for Medical Purposes Only)
Street Address: _____ Street _____ City _____ State _____ Zip _____
Mailing Address: _____ Street _____ City _____ State _____ Zip _____
Person financially responsible: _____ Home Phone: () _____

Parents' Information

Mother's Full Name: _____ Social Security #: _____
Birthdate: _____ Marital Status: Single Married Divorced Separated Widowed
Full Mailing Address: _____
City: _____ State: _____ Zip: _____
Street Address: _____
City: _____ County: _____ State: _____ Zip: _____ E-Mail Address: _____
Home Phone: () _____ Work Phone: () _____
Employment (Name & Address) _____

Father's Full Name: _____ Social Security #: _____
Birthdate: _____ Marital Status: Single Married Divorced Separated Widowed
Full Mailing Address: _____
City: _____ State: _____ Zip: _____
Street Address: _____
City: _____ County: _____ State: _____ Zip: _____ E-Mail Address: _____
Home Phone: () _____ Work Phone: () _____
Employment (Name & Address) _____

Emergency Contact

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

Name: _____ Relationship to Patient: _____
Home Phone: () _____ Work Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____

Please check this box if you will permit ABC Pediatrics to leave messages on your home voice mail regarding your child's appointment time, prescription availability, etc..

Insurance Information

Primary:

Subscriber's Full Name: _____ ID #: _____

Insurance Company Name: _____ Group #: _____

Secondary:

Subscriber'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) |

Patient's Daycare/School

Primary/Secondary Pharmacy

Please provide the name, address, and phone number of your child's school or daycare facility:

Please provide the name, address, and phone number of your primary and secondary/after-hours pharmacy choices:

<u>Primary</u>	<u>Secondary/Afterhours</u>
Name	Name
Address	Address
Phone Number	Phone Number

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: _____



TO OUR VALUED PARENTS/PATIENTS

ABC Pediatrics is in the process of converting from paper records to Electronic Health Records. Electronic Medical Records is rapidly becoming the "industry standard" within the health care field and is greatly improving the efficiency of record-keeping within medical offices. Electronic Health Records will also benefit the patient - among other things, your provider will have immediate access to the patient's entire medical history, lab and x-ray results will be immediately available, appointment scheduling, check-in and check-out will be faster and more efficient, and prescriptions can be transmitted electronically to your pharmacy to enable you to obtain your medications faster and without an extended wait time.

To better serve you, in conjunction with our conversion to Electronic Health Records, we are asking that you provide us with an email address if you have one. We will keep your email address confidential and will not use it for any other reason other than communicating with you. Our future goal is to provide you with a means of accessing your child's medical records and as a means of communicating with our office electronically from your home computer. Utilizing today's technology, we intend to make this interaction private, confidential and secure.

Information regarding names, addresses, and employment is, of course, necessary for us to have in order to contact you regarding your child's visits to our office, prescriptions, and other information which we may need to provide to you either by mail or by phone. Additionally, we request the name and phone number of a relative or friend as someone who can provide assistance in locating you if we cannot reach you at home or at work. Please be sure to indicate the correct area code for all phone numbers. Also, as there are various race-specific illnesses (i.e., Sickle Cell Anemia, etc.), we request that you indicate the patient's race. This information is for medical purposes only.

We also request that you provide to us the names of any/all individuals whom you have authorized to seek and approve medical care for your child. When your child is brought to our office by anyone other than the parent/guardian and their name is on the list provided by you, we will know that you have authorized this person to bring your child for medical care and you will not be bothered by having to provide a note/letter authorizing us to treat your child.

Information regarding your insurance coverage is necessary to enable us, as your child's medical care provider, to receive payment for services rendered to you and for you to receive reimbursement for fees you have paid to the provider for services rendered.

Please fill out the information requested on the attached form and return to the Check-In or Check-Out Receptionist. We sincerely appreciate your cooperation in this matter, and if you should have any questions, please feel free to speak to anyone in the Front Office.

Thank you....

ABC Pediatrics

104 Tilghman Drive, Dunn, NC 28334
Tel: (910) 892-1333 - Fax: (910) 892-2929