

PEDIATRIC CARE SPECIALISTS
PATIENT INFORMATION SHEET

Patient Name _____ SS# _____ DOB _____
Address _____ City _____
State _____ Zip Code _____
Home Telephone _____ Work Telephone _____

Father's Name _____ SS# _____ DOB _____
Address _____ City _____
State _____ Zip Code _____
Home Telephone _____ Work Telephone _____
Place of Employment _____

Mother's Name _____ SS# _____ DOB _____
Address _____ City _____
State _____ Zip Code _____
Home Telephone _____ Work Telephone _____
Place of Employment _____

Insurance Information

Primary Insurance Name _____ ID# _____ Group# _____
Secondary Insurance Name _____ ID# _____ Group# _____

I am aware that under the HIPAA regulations, this office has the right to contact me regarding billing, claims management, and collection activities.

I authorize Pediatric Care Specialists to treat my child with myself or other authorized person(s) present during visit

I authorized Pediatric Care Specialists to contact the named individual for my emergency contact with issues related to the overall care of my child including, however, not limited to test results, account information, and treatment consent.

Signature _____ Date _____

Emergency Contact information (Other than primary residence)

Name _____ Relationship _____
Phone number _____

I have received a copy of Pediatric Care Specialists' Notice of Privacy Practices

Signature _____ Date _____

I have refused a copy of Pediatric Care Specialists' Notice of Privacy Practices

Signature _____ Date _____