Updated: Oct-16

CONFIDENTIAL – PATIENT INFORMATION SHEET / CONSENT FORM

PATIENT LEGAL NAME____ ☐ Male ☐ Female

Birth Date______________ Age ________ Home Phone # ________________________________

Address_______________________________________City____________________________Zip Code_____________

All names must be written as LEGAL NAME to match GOVT PHOTO ID

Child lives with: ☐ Mother ☐ Father ☐ Both ☐ Guardian/Foster Parent

Legal Mother's/ Legal Guardian's Name ___________________________Cell # ______________Email: ________________

Legal Father's/ Legal Guardian's Name ____________________________Cell # _____________ Email:________________

Responsible Party ____ Relationship ___________________

Billing Address____ Phone #_________________________

Emergency Contact Information

(OTHER THAN PARENT/GUARDIAN)

(This is not a 3rd Party Auth to Treat – Please complete additional form):

Name____ Phone #________________________________

Relationship to the Patient: ______________________________

Insurance Information ☐ Patient does not have medical insurance

Name of Insured (Subscriber)__________________________________ Insured's Birthdate____________________________

Name of Insurance Plan: _____________________________________ Insurance ID# _________________________________

CONSENT FOR TREATMENT: I hereby authorize medical treatment for the above named child. I authorize emergency medical treatment for the above named child, in the event, that he/she is brought into this medical practice by any person other than myself.	Initials
I hereby acknowledge that I have been offered a copy of this medical practice's HIPAA-Notice of Privacy Practices. I further acknowledge that a copy of the current notice is made available/posted in the waiting area, and that I will be offered a copy of any amended **Notice of Privacy Practices** at each appointment. Pediatric Partners may disclose immunization records to **schools only** for the purpose of registration/admittance requirements upon **my verbal request**.	Initials
I am aware Pediatric Partners participates in the secure exchange of data with Public Health Registries, Syndromic Registries, or other HIE database/facility in coordination of patient care. **(Data Sharing)**	Initials
I hereby authorize and request my insurance company to pay directly to the physician benefits otherwise payable to me. I understand that my medical insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. **(Assignment of Benefits)**	Initials
I am aware the **Notice of Nondiscrimination** is posted in the waiting room of each clinical site at Pediatric Partners.	Initials

Parent/Guardian Signature: ____ Date: _________________________

Print Parent/Guardian Name & Relationship: ____

NOTICE TO CONSUMERS Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov