GROWING KIDS PEDIATRICS

PATIENT INFORMATION

Child(ren)'s Name:	Name child likes to be called:	DOB:	Sex:	SSN:
1.				
2.				
3.				
4.				

Primary Language Spoken:
Ethnicity (select one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race (select one): ☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than 1 Race

Patient's primary phone number:	**Email:**

Parent 1/Guarantor (Person who is signing form)	**Parent 2 Information**
Relationship to Patient: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian	**Relationship to Patient:** ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian
Full Name:	**Full Name:**
Address 1:	**Address 1:**
Address 2:	**Address 2:**
City:	**City:**
State: **Zip**:	**State**: **Zip**:
Home Phone#:	**Home Phone#:**
Work Phone#:	**Work Phone#:**
Email:	**Email:**
Cell Phone#:	**Cell Phone#:**
Date of Birth:	**Date of Birth:**
SSN:	**SSN:**

Employer:	**Employer:**

Lives with patient (circle one)? Yes No	**Lives with patient (circle one)?** Yes No
☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Custodial Parent** ☐ **Guardianship** ☐ **Joint Custody**	☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Custodial Parent** ☐ **Guardianship** ☐ **Joint Custody**

INSURANCE INFORMATION:

Primary Insurance:	**Secondary Insurance**:
Certificate#:	**Certificate#:**
Group Number:	**Group Number**:
Group Name:	**Group Name**:
Subscriber Name:	**Subscriber Name**:
Subscriber DOB:	**Subscriber DOB**:
Subscriber SSN:	**Subscriber SSN:**

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Anyone authorized below can accompany the child(ren) and give consent for treatment. This would include immunization(s) consent and telephone medical advice and make appointments.

1.	**Phone #:**	**Relation:**
2.	**Phone #:**	**Relation:**
3.	**Phone #:**	**Relation:**
4.	**Phone #:**	**Relation:**

I acknowledge that Growing Kids Pediatrics, LLC has provided me a copy of its Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information. I also acknowledge that the above information is true and accurate. _____

Initial

Privacy constraints (check one):

___ No restrictions: Okay to leave message/send mail.
___ Restrictions: Person to person with patient/guardian only
___ Restrictions: _____

Authorization to Release Medical Information. I hereby authorize my Provider to release any information necessary for my course of treatment. _____

Initial

I hereby assign, transfer, and set over to Growing Kids Pediatrics, LLC, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided through Growing Kids Pediatrics, LLC and I understand that no guarantee of results has been made.

_____ _____

Signature (parent/guarantor if minor) **Date**

_____

Parent / Guarantor Printed Name