CENTRE PEDIATRIC ASSOCIATES, PC
PATIENT INFORMATION FORM

Please name the primary care physician (PCP) you have chosen: _____

Please write the name (s) of any other children currently being seen in this office: _____

Please PRINT CLEARLY the following information:

Child's Last Name: _____First Name: _____MI:_____

Child's Date of Birth: Month: _____Day: _____Year:_____ Sex: M [ ] F [ ]

Guarantor Parent's Last Name:_____ First Name: _____MI: _____

Parent's Date of Birth: _____/_____/_____ Social Security Number: _____/___/_____ Sex: M [[F [ ]

Second Parent's Last Name: _____ First Name: _____MI:_____

Parent's Date of Birth: _____/_____/_____ Social Security Number: ____/___/_____ Sex: M [ ] F [ ]

Phone Numbers: Home: ( ) _____ Guarantor's Work Number: ( ) _____

Cell: ( ) _____ Second Parent's Work Number: ( ) _____

Address: Number and Street: _____

City, State and Zip Code: _____

Billing Address: (if different) _____

Email address: _____

Are you Native American (American Indian) or Alaskan Native: Yes [ ] No [ ]
Primary language spoken in home: _____ Ethnicity:_____Race:_____

Insurance Information (Please attach a copy of your child's insurance card)

Insurance Carrier Name: _____

Subscriber's Name: _____Subscriber's Date of Birth: _____/_____/_____

Employer's Name and Address:_____

Member # (if applicable) _____ Group Number: _____

Identification Number: _____ Child's Suffix (if applicable) _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance due on my account for all services rendered by Centre Pediatric Associates, PC including any late fees and/or service charges. I understand that all co-payments are due and payable at the time of the visit. I have read all the information on this form and have completed all the answers. I will notify you of any changes in my health insurance status or any of the above information.

Parent (Guardian) Signature_____ Date: _____

Centre Pediatric Associates, PC

Notice of Privacy Practices Acknowledgement and Consent

CENTRE PEDIATRIC ASSOCIATES, PC

By signing below, I acknowledge that I have been provided a copy of the Centre Pediatric Associates, PC Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of medical group, its staff, and its business associates.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date