

Kids & Teens Primary Healthcare, P.C.

Patient Information

Child's Legal Name: _____ Nickname: _____
Birth Date: _____ Sex: Male or Female
Who does the child live with? MOM DAD BOTH or
OTHER _____ (provide full name/relationship)
Patient's Home Address:
Home Address _____ City _____ State _____
Zip Code _____ Phone Number _____ Cell Number _____
Best Phone Number to contact or leave a message _____
Mother's Name _____ Father's Name _____
Date of Birth _____ Date of Birth _____
Social Security Number _____ Social Security Number _____
Email Address _____ Email Address _____
Contact Phone Number _____ Contact Phone Number _____
Work Phone Number _____ Work Phone Number _____
Employer _____ Employer _____
Occupation _____ Occupation _____
Pharmacy Name: _____ Phone Number: _____
Address: _____ City: _____
Primary Insurance: _____ Secondary Insurance: _____
Address _____ Address _____
City _____ State _____ Zip code _____ City _____ State _____ Zip code _____
Policy Number _____ Policy Number _____
Group Number _____ Group Number _____
Insured Name _____ Insured Name _____
Relationship to Patient _____ Relationship to Patient _____
Co-Pay Amount \$ _____ Co-Pay Amount \$ _____
List all siblings on this form:
Last Name, First Name _____ Date of Birth _____ Male Female
Last Name, First Name _____ Date of Birth _____ Male Female
Last Name, First Name _____ Date of Birth _____ Male Female
Last Name, First Name _____ Date of Birth _____ Male Female
Emergency Contact
Name _____ Relationship _____ Phone Number _____
Name _____ Relationship _____ Phone Number _____
Who referred you to our office:
 Friend _____ Relative/Family member _____
 Yellow Pages Insurance _____ Other _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please sign below that you have been offered the HIPAA Notice or an opportunity to review a copy of our HIPAA Notice. You are entitled to a personal copy of the notice at any time to keep for your records. If you have any questions about our privacy practices, please feel free to contact our office manager.

Signature of Parent/Guardian/Representative/Patient: _____

CANCELLATION POLICY

Your appointment is important to you, your doctor and to others who are in need of medical care. We ask that you provide a 24 hour notice for one child's visit and we request a 48 hour notice if more than one child are scheduled. We reserve the right to charge a no show fee for cancellations without notice.

Signature of Parent/Guardian/Representative/Patient: _____

FINANCIAL AGREEMENT

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to the physician. I understand that I am financially responsible for any balance or service not covered by my insurance. I also authorize Kids and Teens Primary Healthcare or insurance company to release any information required to process my claims. I authorize a copy of this consent to be used in place of the original. I also authorize release of private health information to other providers involved in my child's care.

Signature of Parent/Guardian/Representative/Patient: _____