Camelback Pediatrics, PC

PATIENT INFORMATION FORM

Please Complete This Entire Form (list all children the information applies to)

PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD

LAST NAME: GENDER: □ *M* □ *F*	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
LAST NAME: GENDER: □ *M* □ *F*	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
LAST NAME: GENDER: □ *M* □ *F*	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
LAST NAME: GENDER: □ *M* □ *F*	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:
LAST NAME: GENDER: □ *M* □ *F*	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH:

MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS (*If different*):	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:

E-MAIL ADDRESS:

ENABLE FOR PATIENT PORTAL: □ Yes □ No □ Not Applicable

PREFERRED LANGUAGE: □ English □ Spanish □ Other Language (*Please specify*):

ETHNICITY: □ Hispanic/Latin □ Non-Hispanic/Latin □ Decline to Report

RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American □ White □ Native Hawaiian/Other Pacific Islander □ Other □ Decline to Report

GUARANTOR INFORMATION

(Individual responsible for bills and payment)

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO CHILD (*Check all that apply*): □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Other *(Please specify)*:
STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:
E-MAIL ADDRESS: □ None	SOCIAL SECURITY #:	DATE OF BIRTH (*mm/dd/yyyy*):	
GENDER: □ Male □ Female □ Other	EMPLOYER NAME:	EMPLOYER PHONE #: ( )	

OCCUPATION:

MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

ADDITIONAL CONTACT #1

LAST NAME:	FIRST NAME:	RELATIONSHIP TO CHILD (*Check all that apply*): □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Other *(Please specify)*:	
STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	DATE OF BIRTH (*mm/dd/yyyy*):	

OCCUPATION:

MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

PLEASE CONTINUE ON THE NEXT PAGE

ADDITIONAL CONTACT #2 (OPTIONAL)

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP TO CHILD *(Check all that apply)*:** □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Other *(Please specify):*	
STREET ADDRESS: □ ***Check if same as patient***	**CITY:**	**STATE:**	**ZIP:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**DATE OF BIRTH *(mm/dd/yyyy)*:**	
OCCUPATION:	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ Yes □ No		

INSURANCE INFORMATION

(***Please present all current insurance cards to the Front Desk)***

I HAVE INSURANCE: ☐ Yes ☐ No ***(Self Pay)***			
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
SUBSCRIBER:	**RELATION:**	**SUBSCRIBER:**	**RELATION:**
Policy ID:	**Group ID:**	**Policy ID:**	**Group ID:**
GENDER: □ Male □ Female □ Other		**GENDER:** □ Male □ Female □ Other	
DATE OF BIRTH:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**	**SOCIAL SECURITY #:**

CONFIDENTIAL COMMUNICATION

(***I hereby request to receive confidential communications from Camelback Pediatrics, PC in the following manner)***

TELECOMMUNICATIONS – Please leave messages as follows (Check All That Apply): ☐ **Home Phone of Record** ☐ **Brief** ☐ **Detailed** ☐ **Cell Phone of Record** ☐ **Brief** ☐ **Detailed**	**APPOINTMENT CONFIRMATIONS – Please remind via: (*Check one)*** ☐ **Cell Phone – text message (recommended)** ☐ **Home Phone – automated call** ☐ **Email address**

Telephone Contacts

I hereby consent and agree that: (1) anyone acting on behalf of Camelback Pediatrics, PC (herein known as "CP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of CP's contacts with me may be made via text message or with an automated dialing and announcing or similar device; (3) CP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with CP and that CP may contact me at the telephone number I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying CP staff. □ **Accept** □ **Decline** **Initials:** _____

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize Camelback Pediatrics, PC to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of Camelback Pediatrics, PC for medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If Camelback Pediatrics, PC is not a provider on my insurance, full payment is due on the date of service. If Camelback Pediatrics, PC is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay additional fees such as 5% of the balance due, collection agency charges, attorney's fees, and any other costs.

By signing below, I am acknowledging that I have read and understand the above statements.

_____	_____	_____
Parent or Legal Guardian Printed Name	**Parent or Legal Guardian Signature**	**Date Signed**