BRENTWOOD PEDIATRIC CARE

PATIENT INFORMATION

Name of Patient and all Siblings (First, Middle, Last Name)	*Sex*	*Birth Date*
*1.*_____	☐M ☐F	_____
*2.*_____	☐M ☐F	_____
*3.*_____	☐M ☐F	_____
*4.*_____	☐M ☐F	_____
*5.*_____	☐M ☐F	_____

Preferred Language* (Patient) ☐English ☐Spanish ☐Other _____

Race* ☐American Indian or Alaskan Native ☐Asian ☐Black ☐Hawaiian Native or Pacific Islander ☐White ☐Declined to Answer

Ethnicity* ☐Hispanic ☐Non-Hispanic ☐Other _____

PARENT/GUARDIAN INFORMATION

Responsible Party Name: _____ Relationship to Patient(s) _____

Birthdate: _____ SS #_____ Email: _____

Occupation; _____Employer: _____

Insurance: _____ Member ID _____

Group ID:_____ Effective Date _____

Other Parent or Guardian: _____Relationship to Patient(s) _____

Birthdate: _____ SS #_____ Email: _____

Occupation; _____Employer: _____

Responsible Party Address_____

City_____ State _____ Zip _____

Primary Phone: _____ Secondary Phone: _____

Preferred Contact Method for appointment reminders: ☐Phone ☐Text ☐Email

How did you hear about us? _____

_____

Please list below any additional persons who may bring the child (children) to appointments, or who are authorized to communicate with regarding visits, medical information (grandparents, nanny, etc):

Contact Name: _____ Relationship: _____ Phone #: _____

Contact Name: _____ Relationship: _____ Phone #: _____

Contact Name: _____ Relationship: _____ Phone #: _____

In an emergency please contact (other than listed above): _____

Authorization and Consent for Treatment, Assigning of Benefits and Financial Responsibility

• I hereby authorize Brentwood Pediatric Care to provide medical services to the above named patient(s) and to use and release medical information as required for treatment and health care operations.

• I understand that I am financially responsible for all professional charges that I may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed. I understand that Insurance Cards should be presented at every visit

• I hereby authorize payment of medical benefits directly to Brentwood Pediatric Care. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.

• Acknowledgment of Receipt of HIPAA NOTICE OF PRIVACY PRACTICES: I have received, or have been given the opportunity to receive, a copy of HIPAA Notice of Privacy Brentwood Pediatric Care.

_____ _____

Patient (Over 18)/Parent/Guardian Signature