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 _____

Race: ☐American Indian ☐Alaskan Native ☐Asian ☐Black ☐Hawaiian Native ☐White ☐Decline to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Other _____

PARENT/GUARDIAN INFORMATION

Responsible Party/Legal Guardian:

Name _____ Birthdate _____

Address_____Apt._____

City_____State_____Zip_____

Phone _____ Relationship to Patient(s) _____

Insurance Card Presented: ☐ Yes ☐ No No Insurance (Self Pay): ☐ Yes ☐ No

Other Parent/Other Legal Guardian:

Name _____ Birthdate _____

Address_____Apt._____

City_____State_____Zip_____

Phone _____ Relationship to Patient(s) _____

Preferred contact method for appointment reminders: ☐ Phone ☐ Text ☐ Email

How did you hear about our office? _____

Authorization to Treat a Minor

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

Name _____

Relationship _____ Phone _____

Name _____

Relationship _____ Phone _____

Name _____

Relationship _____ Phone _____

In an emergency, please contact _____

_____

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 are to be presented before checking in for an appointment whenever there is a change in insurance plan or at the beginning of a new year.

- 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 *Date*