



I. PATIENT INFORMATION

TODAY'S DATE _____

Child's Legal Name: _____ Nickname _____

Birthdate: _____ Age: _____ Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Child is living with: Natural Parents Adoptive Parents One Parent Alone Parent and Step-Parent Other _____
Home Phone: _____
Cell Phone: _____
Cell Phone: _____

Status of Parents: Married Separated Divorced Widowed Unmarried

II. FAMILY HISTORY:

Mother: Natural Adoptive Foster

Name: _____ Birthdate _____

SS# _____ Employer: _____ Phone _____

Father: Natural Adoptive Foster

Name: _____ Birthdate _____

SS# _____ Employer: _____ Phone _____

If child is living with step-parent or other relative, please complete the following:

Name: _____ Birthdate _____

SS# _____ Employer: _____ Phone _____

III. INSURANCE

Primary: _____ Insured's Name _____

Group Name or Number: _____ ID# _____

Secondary: _____ Insured's Name _____

Group Name or Number: _____ ID# _____

I Authorize Pediatric Care North to release any and all medical records pertaining to my child's health to my insurance company for any requested additional information. Parent's Signature _____

The above patient information is correct and there are no changes.

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act allows individuals to request restrictions on uses and disclosures of their protected health information. Further, the individual may request confidential communications to be made by alternative means.

PATIENT NAME: _____ DATE OF BIRTH: _____

Pediatric Care North has my permission to release protected health information to the following person(s).

1. _____ Relationship _____

2. _____ Relationship _____

With this consent, Pediatric Care NorthA may call home or another alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out Treatment, Payment and Healthcare Operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Pediatric Care North may mail to my home or another alternative location any items that assist the practice in carrying out Treatment, Payment and Healthcare Operations (TPO), such as patient statements as long as they are marked Personal and Confidential.

I hereby acknowledge that I have been given a copy of Pediatric Care North's Notice of Privacy Practices.

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____