# ASHEVILLE PEDIATRICS
# PATIENT INFORMATION SHEET

**ACCOUNT NO:** ____________________ **DATE:** ______________ **Physician:** ___________________________

**LANGUAGE SPOKEN:** _____________________ **LANGUAGE SERVICES NEEDED? (circle one):** YES NO

**Ethnicity (circle one):** HISPANIC OR NOT HISPANIC

**RACE (circle one):** ASIAN, BI-RACIAL, BLACK/AFRICAN-AMERICAN, WHITE, HISPANIC OR LATINO, OTHER

| | | | | | |
|---|---|---|---|---|---|
| **CHILD'S NAME: LAST** | **FIRST** | **MI** | ____/____/____ **DATE OF BIRTH** | **SEX** | ______-______-______ **SSN** |
| **CHILD'S NAME: LAST** | **FIRST** | **MI** | ____/____/____ **DATE OF BIRTH** | **SEX** | ______-______-______ **SSN** |
| **CHILD'S NAME: LAST** | **FIRST** | **MI** | ____/____/____ **DATE OF BIRTH** | **SEX** | ______-______-______ **SSN** |
| **CHILD'S NAME: LAST** | **FIRST** | **MI** | ____/____/____ **DATE OF BIRTH** | **SEX** | ______-______-______ **SSN** |
| **CHILD'S NAME: LAST** | **FIRST** | **MI** | ____/____/____ **DATE OF BIRTH** | **SEX** | ______-______-______ **SSN** |

**FATHER'S INFORMATION:**

**NAME: LAST** **FIRST** **MI** ____/____/____ **DATE OF BIRTH** ______-______-______ **SSN**

**BILLING ADDRESS:** **CITY** **STATE** **ZIP** **HOME PHONE #**

**E-MAIL ADDRESS** **CELL PHONE #**

**EMPLOYER** **WORK PHONE #**

**MOTHER'S INFORMATION:**

**NAME: LAST** **FIRST** **MI** **MAIDEN** ____/____/____ **DATE OF BIRTH** ______-______-______ **SSN**

**BILLING ADDRESS:** **CITY** **STATE** **ZIP** **HOME PHONE #**

**E-MAIL ADDRESS** **CELL PHONE #**

**EMPLOYER** **WORK PHONE #**

**PERSON RESPONSIBLE FOR PAYMENT** **PERSON PROVIDING INFORMATION** **EMERGENCY CONTACT & PHONE #**

## PLEASE COMPLETE OTHER SIDE

I, ______________________________, GIVE AUTHORIZATION FOR MEDICAL RECORD/PRESCRIPTION PICK-UP, MEDICAL INFORMATION, AND TO BRING ________________________________ TO DOCTOR APPOINTMENTS TO THE FOLLOWING:

______________________________________________________________________
AUTHORIZED PERSONS NAME & PHONE NUMBERS RELATIONSHIP TO PATIENT

______________________________________________________________________
AUTHORIZED PERSONS NAME & PHONE NUMBERS RELATIONSHIP TO PATIENT

______________________________________________________________________
AUTHORIZED PERSONS NAME & PHONE NUMBERS RELATIONSHIP TO PATIENT

## GENERAL CONSENT TO TREAT:

I AUTHORIZE AND REQUEST ASHEVILLE PEDIATRICS ASSOC., P.A. TO PROVIDE DIAGNOSTIC TESTING & TREATMENT FOR ____________________________________________.

______________________________________________________________________
PARENT/GUARDIAN SIGNATURE DATE

## INSURANCE INFORMATION:

TYPE OF PRIMARY INSURANCE: ____________________________________________

PRIMARY SUBSCRIBER: _________________________________ BIRTHDATE: ____________________

POLICY NUMBER: ___________________________________ GROUP NUMBER: ____________________

TYPE OF SECONDARY INSURANCE: ___________________________________________

SECONDARY SUBSCRIBER: ______________________________BIRTHDATE: ____________________

POLICY NUMBER: ___________________________________ GROUP NUMBER: ____________________

INSURANCE RELEASE AND ASSIGNMENT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN PROVIDING SERVICES.

I UNDERSTANDE THAT I WILL BE RESPONSIBLE FOR PAYMENT FOR SERVICES NOT COVERED BY MY INSURANCE POLICY.

_________________________________________ _________________________________________
PRIMARY SIGNATURE DATE SECONDARY SIGNATURE DATE

## NOTICE OF PRIVACY POLICY

I, ____________________________, HAVE RECEIVED A COPY OF ASHEVILLE PEDIATRICS PRIVACY POLICY. I AUTHORIZE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ABOUT ________________________________ TO ASHEVILLE PEDIATRICS. THIS AUTHORIZATION WILL EXPIRE IN TEN YEARS FROM DATE SIGNED.

______________________________________________________________________
SIGNATURE OF PARENT/GUARDIAN DATE