WEST CHESTER PEDIATRICS

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PATIENT INFORMATION

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ______

D.O.B.: ______ / ______ / ______ SEX: __________

INSURANCE INFORMATION

PRIMARY: POLICY HOLDER'S NAME: ______________________

POLICY HOLDER'S BIRTH DATE: ______________________ POLICY HOLDER'S SEX: MALE / FEMALE

INSURANCE CARRIER: ______________________ POLICY HOLDER'S SSN: ______ / ______ / ______

POLICY ID #: ______________________ GROUP #: ______________________

SECONDARY: POLICY HOLDER'S NAME: ______________________

POLICY HOLDER'S BIRTH DATE: ______________________ POLICY HOLDER'S SEX: MALE / FEMALE

INSURANCE CARRIER: ______________________ POLICY HOLDER'S SSN: ______ / ______ / ______

POLICY ID #: ______________________ GROUP #: ______________________

PATIENT MAILING ADDRESS:

____

ADDRESS APT. # CITY STATE ZIP

PRIMARY PHONE # (__________) ______________________

WHO LIVES AT THIS HOUSEHOLD: ______________________

(PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S SOCIAL HISTORY)

LEGAL PARENT *(Not Step-Parent)*, OR LEGAL GUARDIAN 1:

NAME ______________________ DATE OF BIRTH ______ / ______ / ______

LIVES WITH PATIENT? YES / NO RELATION TO PATIENT ______________________

(PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S FAMILY MEDICAL HISTORY)

IF **NO**, PLEASE LIST CONTACT'S PRIMARY PHONE NUMBER: ______________________ IS THIS A CELL PHONE? YES / NO

AND THEIR ADDRESS ______________________

WORK PHONE # ______________________ CELL PHONE # ______________________

SOCIAL SECURITY # ______ - ______ - ______ OCCUPATION ______________ PLACE OF EMPLOYMENT ______________

LEGAL PARENT *(Not Step-Parent)*, OR LEGAL GUARDIAN 2:

NAME ______________________ DATE OF BIRTH ______ / ______ / ______

LIVES WITH PATIENT? YES / NO RELATION TO PATIENT ______________________

(PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S FAMILY MEDICAL HISTORY)

IF **NO**, PLEASE LIST CONTACT'S PRIMARY PHONE NUMBER: ______________________ IS THIS A CELL PHONE? YES / NO

AND THEIR ADDRESS ______________________

WORK PHONE # ______________________ CELL PHONE # ______________________

SOCIAL SECURITY # ______ - ______ - ______ OCCUPATION ______________ PLACE OF EMPLOYMENT ______________

STEP-PARENT *(Release Required)* OR EMERGENCY CONTACT

NAME ______________________ RELATIONSHIP ______________________

PHONE # ______________________

ADDITIONAL CONTACT QUESTIONS

WHO SHOULD RECEIVE BILLING STATEMENTS? ______________________________

IS THE ADDRESS THE SAME AS THE PATIENT? YES / NO

IF **NO**, PLEASE SUPPLY THE ADDRESS:

____

IF PARENTS ARE DIVORCED OR SEPARATED, PLEASE FILL OUT THIS SECTION:

WHO HAS CUSTODY? ______________________________

ARE THERE ANY LEGAL RESTRICTIONS THAT WOULD RESTRICT THE NON-CUSTODIAL PARENT FROM CONSENTING TO MEDICAL TREATMENT FOR THE CHILD OR FROM OBTAINING INFORMATION ABOUT THE CHILD'S MEDICAL TREATMENT: YES / NO

IF YES, PLEASE EXPLAIN AND PROVIDE A COPY OF ANY LEGAL PAPERWORK THAT SUPPORTS THIS RESTRICTION:

____

PLEASE READ CAREFULLY: ***The following statement cannot be edited or altered in any way.***
By my signature, I authorize West Chester Pediatrics, Inc. (WCP) to examine and provide medical treatment. I authorize WCP to release any medical or incidental information that may be necessary for either medical care or in the processing applications for financial benefit. I authorize my insurance company to issue payment directly to WCP. I assume full responsibility for any balance due after my insurance benefit has been processed and will remit it immediately upon receipt of a billing statement. I understand that 1) It is my responsibility to know all rules and restrictions of my insurance policy, to know which hospitals, emergency rooms, lab facilities, radiology departments, specialists which are assigned to me according to my insurance policy rule. 2) Copay and/or co-insurance is due at time of service. 3) It is my responsibility to supply WCP with the correct insurance information as well as any changes to my mailing address and telephone numbers. 4) Any costs WCP incurs as a result of debt recovery on my account will be passed along to me. 5) It is WCP's policy to disclose Protected Health Information in accordance with HIPPA Privacy and Security standards for Treatment, Payment and Health care operations.

X ______________________________ ______________ ___/___/___

SIGNATURE OF PARENT OR GUARDIAN RELATIONSHIP DATE