West Chester Pediatrics

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Patient : Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____

Insurance Information

Primary Policy: 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: 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:

_____

(Street or PO Box) (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.)

Ideally, who would be best to attempt to contact first regarding the listed items:

Name: _____

Please circle one for each:

Medical Issues: Home Phone / Work Phone / Cell Phone

Appointment Reminders: Home Phone / Cell Phone / Text to Cell

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Text to Cell

Patient Portal Notifications: Email / Text to Cell

Contact Information

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No

If ***no***, please list Contact's primary phone number: _____ Is this a cell phone? Yes / No

and their Address: _____

Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home / Work email (please circle)

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No

If ***no***, please list Contact's primary phone number: _____Is this a cell phone? Yes / No

and their Address: _____

Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home / Work email (please circle)

Emergency Contact, <u>other than parents</u>:

Name _____ Relationship _____

Phone: (___) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No

If no, list who may have access

_____

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 ***<u>provide a copy of any legal paperwork that supports this restriction</u>*:**

_____

<u>PLEASE READ CAREFULLY</u>, The following statements 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 know that 1) It is my responsibility to know all the rules and restrictions of my insurance policy, to know which hospital, emergency room, lab facility, radiology department, and specialist 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 contact information. 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 HIPAA Privacy and Security standards for Treatment, Payment and Health care operations.

_____

SIGNATURE OF PARENT OR GUARDIAN RELATIONSHIP DATE