PEDIATRICS IN BREVARD

NEW PATIENT INFORMATION

Today's Date: _____

Patient's Name _____

Date of Birth _____ Sex ☐ M ☐ F

Patient Address _____

_____

City State Zip

Phone # Home _____ Cell _____

E-Mail address _____

Race (*check one*)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Island ☐ White ☐ Declines to respond

Preferred Language ☐ English ☐ Spanish ☐ Other (specify)_____

Ethnicity (*check one*) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to Respond

Vision or Hearing Barriers to Communication? ☐ Yes ☐ No

If yes, please specify_____

Patient Resides with

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Parent's current marital status (*check one*) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mother/Legal Guardian

Name _____

DOB_____ SS# _____

Mailing Address_____

_____

City State Zip

Home (___) _____-_____

Work (___) _____-_____

Cell (___) _____-_____

Employer _____

Father/Legal Guardian

Name _____

DOB_____ SS# _____

Mailing Address _____

_____

City State Zip

Home (___) _____-_____

Work (___) _____-_____

Cell (___) _____-_____

Employer _____

Who has Custody? ☐ Both ☐ Father ☐ Mother ☐ Other _____(specify)

(Please provide legal documentation for any custody arrangements)

(see reverse side)

Siblings: List full name, Date of Birth, Sex and medical problems:

1. _____ DOB _____ ☐ M F ☐

Medical Problems: _____

2. _____ DOB _____ ☐ M F ☐

Medical Problems: _____

3. _____ DOB _____ ☐ M F ☐

Medical Problems: _____

4. _____ DOB _____ ☐ M F ☐

Medical Problems: _____

Emergency Contacts (other than Parents or Legal Guardians):

Name_____ Relation to patient: _____ Phone # (home, work, cell)_____

Name_____ Relation to patient: _____ Phone # (home, work, cell)_____

Insurance Information ** Please Note You Will Be Asked For You Insurance Card At **EVERY** Visit**

Insurance Company Name: _____

Policy Holder's Name: _____

First Middle Last

Date of Birth: _____ SS# _____

Policy # _____ Group # _____

Pediatrics in Brevard does not file secondary insurance. This includes Medicaid and Medicaid Managed Care/MMA plans. You will be responsible for all copays, deductibles, coinsurances, etc., that apply to your primary insurances, at the time of service.

Authorization of Treatment and Insurance/Financial Agreement

I/We authorize providers of Pediatrics in Brevard to treat, prescribe medications, obtain prescription history, etc. for the before named patient.

I/We authorize my/our insurance benefits to be paid directly to Pediatrics in Brevard. I/We authorize the release of pertinent medical information, including motor vehicle, disability or employment related information concerning claims to my insurance carriers, authorized agents(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses.

I/We agree that in consideration for the services to be provided by Pediatrics in Brevard to the before named patient, I/We assume responsibilities for payment of all services and account charges/fees, including copayments, co-insurance, deductible, non-covered services and those due to false information.

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

Print Name: _____