

Patient's Full Name: _____ Birth Date: ____/____/____

Patient's Address: _____

Street Address _____ City _____ State _____ Zip Code _____
Sex: ____ Female ____ Male Race (check all that apply) ____ Indian ____ Asian ____ Black ____ White ____ Hawaiian
Primary Language Spoken: ____ English ____ Spanish List Other: _____ Ethnicity: ____ Hispanic ____ Non-Hispanic ____ Unknown

Biological Mother:

Name: _____
Address: _____

City: _____ Zip: _____

Date of Birth: ____/____/____

Home #: _____ Cell#: _____

Cell#: _____

Email: _____

Name of Employer: _____

Do you live with patient? ____ Yes ____ No

Preferred method of contact: ____ Home ____ Cell

Who has primary physical custody? (if applicable): _____

Biological Father:

Name: _____
Address: _____

City: _____ Zip: _____

Date of Birth: ____/____/____

Home#: _____

Email: _____

Name of Employer: _____

Do you live with patient? ____ Yes ____ No

Preferred method of contact: ____ Home ____ Cell

Household:

Please list all those living in the child's home:

Name Relationship Age

Are there siblings, half-siblings or step-siblings not listed?

If so, please list their names and ages and where they live:

Insurance Information:

Primary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: ____/____/____

Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

Insurance ID Number: _____ Effective Date of Plan: ____/____/____

Secondary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: ____/____/____

Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

Insurance ID Number: _____ Effective Date of Plan: ____/____/____

Who is the **Financial Guarantor** (Person who receives billing statements)? _____

Address if not listed above: _____
Street Address _____ City _____ State _____ Zip Code _____

Please list anyone else authorized to be your representative and bring your child/children to appointments:

I understand I can change or revoke the below authorization at any time but I cannot change or revoke names given by another parent.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize the people listed above to bring my child to any appointments in my absence and Meadowbrook Pediatrics, PC may call and leave a message regarding my child's clinical care, including lab and x-ray results in my absence. I understand this authorization for release of information will remain in effect until parent or guardian changes their disclosure with Meadowbrook Pediatrics, PC in writing. At that time this authorization will expire.

I understand that there are copies of the Notice of Privacy available in the office upon request and on the practice website, www.meadowbrookpediatrics.com. I understand both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. I understand if there are Custody Orders in place, I must present current copies for my child's file.

I authorize Meadowbrook Pediatrics, PC, only upon my request, to fax any forms or immunizations records to my child's school. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners.

I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Meadowbrook Pediatrics, PC. I understand that if services rendered are not covered by my insurance company I will be responsible for payment to Meadowbrook Pediatrics PC.

I understand Meadowbrook Pediatrics, PC provides immunization information to the Pennsylvania State Immunization Information System, and I may opt out of having my child's information sent by notifying Meadowbrook Pediatrics, PC in writing. I understand that I am personally responsible for being aware of the dates and times of my scheduled appointments.

Signature: _____

Date:

Relationship to Patient: _____