Independence Pediatrics
Patient Information Form

Date_____

Please Print

Child's Legal Name_____ Date of Birth_____ Sex:(Circle) M F

Social Security No. _____

Where does the child live:
Address_____ City_____ State_____ Zip_____

Home Phone No._____ Alternate Phone No._____

Parent/Legal Guardian Information

Name_____ Date of Birth_____ Relationship to Pt._____

Address_____ City_____ State_____ Zip_____

Home Phone No._____ Cell Phone No._____

Employer_____ Work Phone No._____

Occupation_____ Social Security No._____

Parent/Legal Guardian Information

Name_____ Date of Birth_____ Relationship to Pt._____

Address_____ City_____ State_____ Zip_____

Home Phone No._____ Cell Phone No._____

Employer_____ Work Phone No._____

Occupation_____ Social Security No._____

Primary Insurance Information – A copy of your insurance card is required

Insurance Company_____ Effective Date_____

Address_____ City_____ State_____

Name of Policy Holder_____ DOB_____ Relationship to Pt._____

Certificate/ID No._____ Group Name/No._____

Secondary Insurance Information – A copy of your card is required

Insurance Company_____ Effective Date_____

Address_____ City_____ State_____

Name of Policy Holder_____ DOB_____ Relationship to Pt._____

Certificate/ID No._____ Group Name/No._____

More Information Required on Back--→

Emergency Contact Information (other than Parents)

In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment (including immunizations) for my child/children. I also realize that the person with my child may have access to pertinent protected health information if medically necessary.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

X_____ _____

Signature of Parent/Legal Guardian Date

Release of Protected Health Information

I give permission to release protected health information to:

My daycare/school upon request
Other healthcare providers for purposes related to your care and treatment
We may use and disclose your health information in order to bill and collect payment for services and items you receive.

I hereby allow The Practice to disclose the following protected health information: (Place an x next to those that apply)

__ Appointment times and dates __ Tests that have been received __ Test Results __ Other health information

To the following people because they are directly involved with my health care or payment:

Name _____ Name_____

In the following forms of communication: __Home phone __Cell phone __Work phone __Home voice messaging

__Work voice messaging ___ Other _____

X_____ _____

Signature of Parent/Legal Guardian Date

Practice Financial Policy

It is the financial policy of this office that payment is made at the time the services are rendered. For any missed appointments, in which 24 hours notice is not given, a $45.00 cancellation fee may be applied to your account. For those insured by an insurance plan with which we contract to participate we will adhere to the terms of that contract and will file the necessary claims. For insurance companies for which we do not contract to participate, payment will be expected at the time of service. I understand the above and accept responsibility for payment of services not covered by my insurance policy and/or in the event my coverage has been terminated.

X_____ _____

Signature of Parent/Legal Guardian Date

Sibling Information

Other child(ren) who receive care from our office:

Siblings Legal Name_____DOB_____Sex: M F

Siblings Legal Name_____DOB_____Sex: M F

Siblings Legal Name_____DOB_____Sex: M F

Siblings Legal Name_____DOB_____Sex: M F