

**Independence Pediatrics
Patient Information Form**

Please Print

Child's Legal Name _____ Date of Birth _____ Sex: (Circle) M F

Where does the child live:

Address _____ City _____ State _____ Zip _____

Home Phone No. _____ Alternate Phone No. _____

Parent/Legal Guardian Information (for example Father)

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 (for example Mother)

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. _____

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 id medically necessary.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

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, or

We may use and disclose your health information in order to bill and collect payment for services and items you receive.

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 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 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

Siblings Legal Name _____ DOB _____ Sex: M F