2019 **CENTENNIAL PEDIATRICS**

PATIENT INFORMATION FORM **Date:**

PATIENT INFO: Last Name: First:

Street Address:

City, State, Zip:

Gender: M/F SS#: Date of Birth: Age: Household Primary Language:

MOTHER/GUARDIAN INFO: Last Name: First:

Does Patient Reside with this person? Yes / No Maiden name (if applicable):

Street Address if different from Patient:

City, State, Zip if different from Patient:

SS# Date of Birth: Marital Status:

Employer: Occupation:

Home Phone: Cell Phone: Work Phone:

Home Email: Work Email :

FATHER/GUARDIAN INFO: Last Name: First:

Does Patient Reside with this person? Yes / No

Street Address if different from Patient:

City, State, Zip if different from Patient:

SS# Date of Birth: Marital Status:

Employer: Occupation:

Home Phone: Cell Phone: Work Phone:

Home Email: Work Email :

DEMOGRAPHIC INFO:

What is the primary contact phone number for the patient with area code: _____ Please circle: Cell/Home/Work

How would you like our patient message system to contact you (select one): □Text to cell □ email □Landline message

Ethnicity: (please select one) □ Hispanic or Latino □ NOT Hispanic or Latino □ Decline to answer

Race: (please select all applicable) □ American Indian or Alaska Native □ Asian □ Black/African American
□ Native Hawaiian /Other Pacific Islander □ White/Caucasian □ Decline to answer

AUTHORITY TO OBTAIN MEDICAL TREATMENT:

Additional adults aged 18 or over who are authorized to obtain medical treatment for patient. (If none, please write NONE).

Please note that payment is still due at time of service if child is brought in by an authorized person.

Full Name of Adult:	Relationship:	Phone number:	Does Patient reside with?
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

 Patient Name:

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 authorizing medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of the legal paperwork that supports this restriction.

Primary Insurance Company:

Primary Insured: Relationship to Patient:

Policy #: Group #:

Insurance Claims Address:

Secondary Insurance Company:

Secondary Insured: Relationship to Patient:

Policy #: Group #:

Insurance Claims Address:

Emergency contact (other than listed above): Relationship: Phone:

Other children:

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE COVERAGE! PLEASE READ THE FOLLOWING CAREFULLY! BY SIGNING BELOW, YOU INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THE FOLLOWING POLICIES:

1. I authorize Centennial Pediatrics to provide medical treatment for the patients listed on this form. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize the release of medical records for the purpose of medical referrals, and to the persons listed on this form.
2. I authorize the release of medical information to schools, camps, or other programs after my written or verbal request.
3. I have received and read the HIPAA policy of Centennial Pediatrics.
4. I authorize payment of medical benefits from my insurance company or government program to Centennial Pediatrics.
5. I agree to pay all insurance co-pays and/or coinsurance at the time of check-in and prior to services being rendered.
6. I understand that Centennial Pediatrics does not bill secondary insurance, or accepts checks for copays.
7. I authorize Centennial Pediatrics to display my child's photo that I gave to them, on their wall.
8. If Centennial Pediatrics cannot verify my insurance at the time of visit, or if I do not bring current proof of insurance to each visit, I agree to pay charges in full before the patient is seen.
9. If any charges incurred by me or my dependents are submitted to a collection agency, I agree to pay all fees including, but not limited to, both the collection agency fee and the account balance.
10. If I miss any appointments without prior notification to this office (no show), I agree to pay a $25.00 no show charge.
11. I understand that my family can be discharged from Centennial Pediatrics if we have 3 missed appointments without prior notification (no shows).
12. I agree to pay a $25.00 charge, in addition to the check amount, on any of my personal checks which are returned to this office by my bank.
13. While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Centennial Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. I agree not to hold Centennial Pediatrics responsible in any manner for time spent waiting to be seen.
14. I understand that Centennial Pediatrics bills insurance as a courtesy. I understand that my financial charges for services rendered by Centennial Pediatrics are ultimately my responsibility. Centennial Pediatrics is aware that navigating our healthcare system can be challenging. However, we want our patients to be informed about their insurance coverage. Centennial Pediatrics will attempt to gather and verify the most current information regarding insurance benefits prior to your visit. Benefits can change frequently, and can even be changed retroactively. It is important to know: Do I need a Primary Care Provider (PCP), and if so, is Centennial Pediatrics my PCP? Is Centennial Pediatrics a provider on my insurance? How much is my co-pay and/or deductible? Have I met my deductible? Do I have a separate well care deductible? Does my insurance require that I go to a certain lab to cover the tests? I am aware that this information is vital and I am responsible to understand and confirm my insurance benefits. I have provided Centennial Pediatrics with the correct and current information to assist in verifying my insurance coverage. Understanding insurance benefits can help you to avoid unexpected out of pocket costs.
15. I authorize Centennial Pediatrics to run my credit card by phone with my verbal authorization/request.

Responsible Party (Print): _____ Sign:_____ Date:_____