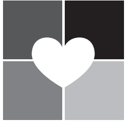

ST. ROSE
PEDIATRICS

St. Rose Pediatrics

It is a policy and requirement for this office to obtain social security numbers from the parents or individuals responsible for the child(ren). If you do not wish to provide us with your social security number, you will need to pay for the visit and will be reimbursed once your insurance company pays the claim. This policy is not negotiable. Thank you for your cooperation.

______________________________	____________________
Child Name	Child Date of Birth
______________________________	____________________
Parent/Legal Guardian Signature	Date

Child 1:

Last Name	First Name	MI

D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White

Mailing Address	Street	City	State	Zip

Home Phone (_______) _______ - ___________	Who lives at this household?

Child 2:

Last Name	First Name	MI

D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White

Mailing Address	Street	City	State	Zip

Home Phone (_______) _______ - ___________	Who lives at this household?

Child 3:

Last Name	First Name	MI

D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White

Mailing Address	Street	City	State	Zip

Home Phone (_______) _______ - ___________	Who lives at this household?

Parent / Guardian (PG1)#1:

Last Name	First Name	MI

D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White

Social Security # ____ - ___ - ______	Lives with Patient (circle) Y N	Reltaion to Patient

Home Address	Street	City	State	Zip

Home Phone (_______) _______ - ___________	Work Phone (_______) _______ - ___________	Cell Phone (_______) _______ - ___________

Home Email	Work Email
Employer	**Occupation**

Parent / Guardian (PG2)#2:

Last Name	First Name	MI

D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White

Social Security # ____ - ___ - _____	Lives with Patient (circle) Y N	Reltaion to Patient

Home Address	Street	City	State	Zip

Home Phone (_______) _______ - ___________	Work Phone (_______) _______ - ___________	Cell Phone (_______) _______ - ___________

Home Email	Work Email
Employer	**Occupation**

How would you ideally prefer to be contacted regarding (Place "x" in box):

	Home Phone		Work Phone		Cell Phone		Home Email		Work Email		Home Address	
	PG1	PG2	PG1	PG2	PG1	PG2	PG1	PG2	PG1	PG2	PG1	PG2
Medical Issues												
Appointment Reminders												
Recall Notices												
Billing Statements												
General Practice Notices												
Patient Portal Notifcations												

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OPUP-1

Signature ____ **Date**____________________

Insurance

Primary Policy

Policy Holder's Name		
D.O.B ______/______/_________	Sex (circle) Male Female	Social Security # ________ - ______ - ________
Insurance Carrier		
ID#	Group #	

Secondary Policy

Policy Holder's Name		
D.O.B ______/______/_________	Sex (circle) Male Female	Social Security # ________ - ______ - ________
Insurance Carrier		
ID#	Group #	

Additional Contact Questions:

Who should receive billing statements? ____

May all contacts have access to the patient's records electronically? Yes / No / __________

If parents are divorced or separated; fill out this section:

Who has custody? ____

Are there any legal restrictions that restrict the non-custodial parent from consenting to 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 any legal paperwork that supports this restriction.

____

____

____

Emergency Contacts, <u>other than parents</u>**:**

Contact #1: ____ Relationship: _______________________

Phone: (_____) ______ - _________

Contact #2: ____ Relationship: _______________________

Phone: (_____) ______ - _________

Pharmacy Information

Name: ____ Phone: (_____) ______ - _________

Address: ____ City:____________________________

State:_____________________ Zip Code:______________

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OPUP-2

Signature ____ **Date**_____________________

PLEASE COMPLETE ALL THE INFORMATION SO WE CAN BILL YOUR INSURANCE

I here by authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to *St Rose Pediatrics* and I understand that I am responsible for charges for medical services rendered to the above-named patient regardless of insurance coverage, including amount not limited to, any and all immunizations.

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION REGARDING MY CHILD OR MYSELF AS DESCRIBED BELOW FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).

Patient Name____
(Nombre paciente)

Patient DOB________________________________
(Paciente fecha del nacimiento)

A. Person(s), Organization(s) authorized to Provide, Use or Disclose the information, i.e, Family Members, Physicians or Others
Person(s), Organization(s) authorized to Receive the information, i.e. Schools, Daycare Centers of Others

1. ____
2. ____
3. ____
4. ____
5. ____

B. Specific description of the information, i,e,, Lab, X-ray and/or all Medical Records. ____________________

____

____

C. This authorization will expire on __________________ (leave open or enter a date)

I authorize that I may revoke this authorization at any time by notifying *St. Rose Pediatrics*. I understand that I can refuse to sign the authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits_________ . I may inspect a copy of any information used or disclosed under the agreement and I have the right to receive a copy of this form. I understand that if the person or organization that receives the information is not a health care provider by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. I understand that this form does not constitute legal advice and covers only federal, not state, law.

______________________________ ____________________
Signature of Patient or Patient's Representative | Date

______________________________ ____________________
Print Name Above | Relationship to Patient

St. Rose Pediatrics
Add/ Change of Insurance Form

Patient Name:___________________________________

Patient Date of Birth:______________________________

Policy Holders Name: _____________________________

Patient Address: _________________________________

City, State, Zip:__________________________________

Old Insurance Company:

Termination Date: ________________________________

New Insurance Company:__________________________

Employer:_______________________________________

Insurance Effective Date: __________________________

****Please attach a copy of the insurance card and verification form behind the form****

Date: ______________

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7220 S. Cimarron Road Suite 155, Las Vegas, NV 89113
P: (702) 564-8556 I F: (702) 564-4485 I www.StRosePeds.com