



ST. ROSE
P E D I A T R I C S

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 (circle) 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 (circle) 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 (circle) 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 (circle) Hawaiian White	
Social Security # ____ - ____ - ____	Lives with Patient (circle) Y N	Relation 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 (circle) Hawaiian White	
Social Security # ____ - ____ - ____	Lives with Patient (circle) Y N	Relation 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 Notifications												

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, other than parents:

Contact #1: _____ Relationship: _____

Phone: (_____) _____ - _____

Contact #2: _____ Relationship: _____

Phone: (_____) _____ - _____

Pharmacy Information

Name: _____ Phone: (_____) _____ - _____

Address: _____ City: _____

State: _____ Zip Code: _____

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: _____