Heights Pediatrics

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Patients Full Name:_____ Date of Birth: _____/_____/_____

◯ Female ◯ Male Hospital Delivered: _____ Did your child receive Hep B in the hospital? _____

Address: _____Apt#:_____ City: _____State:_____ Zip: _____

Race: _____Language: _____Ethnicity:_____ ◯ Decline to Specify

Parent/Guardian Name: _____ Date of Birth: _____/_____/_____

Home Phone:(_____)_____-_____ Cell Phone:(_____)_____-_____Work:(_____)_____-_____

Email Address: _____ Social Security: _____-_____-_____

Parent/Guardian Name: _____ Date of Birth: _____/_____/_____

Home Phone:(_____)_____-_____ Cell Phone:(_____)_____-_____Work:(_____)_____-_____

Email Address: _____ Social Security: _____-_____-_____

Emergency Contact (other than Parent): _____Phone: (_____)_____-_____

Insurance Carrier: _____ ID# _____ Group# _____

Policy Holder: _____ Relationship to Patient: _____SS#_____

Name & Number of Pharmacy: _____, (_____)_____-_____, Zip Code_____

◯ **ONLY PARENTS CAN BRING IN CHILD/REN**

◯ **CONSENT TO PERMIT INDIVIDUALS OTHER THAN PARENTS TO ACCOMPANY CHILDREN FOR TREATMENT** (authorize nanny/grandparent/step-parent/sitter to accompany child(ren) to Heights Pediatrics, P.C. for the provision of medical services and to view/discuss child's protected health information.) Please list all names of individuals allowed to bring in your child(ren).

Name(s): _____

These individuals are able to authorize procedures such as (check categories):

◯ Immunizations ◯ Lab Orders ◯ X-Rays ◯ In-house (strep test, RSV test, flu test, urine test, etc.)

◯ **CONSENT TO TREAT UNACCOMPANIED MINOR AT HEIGHTS PEDIATRICS, P.C.** (Request and authorize Heights Pediatrics, P.C. and its personnel to deliver medical care, this includes routine immunizations, in house lab work and treatments to my MINOR CHILD).

OPTIONAL: Heights Pediatrics, P.C. is authorized to maintain credit card payment information in our confidential files. Your signature authorizes us to review the information and deduct copayments and fees from the credit card below, when you sign the application. We DO NOT take AMEX or DISCOVER.

◯ MASTERCARD ◯ VISA

Cardholder Name: _____ Cardholder Signature: _____

Credit/Debit Card Number: _ _ _ _- _ _ _ _- _ _ _ _- _ _ _ _ Exp Date: ____/____ VCode: _____ Zip: _____

◯I have received a paper copy of the Privacy Practices Notice (HIPAA), Financial Policy and Consent to Treat.

Please provide a copy of immunization records and insurance card.

Parents Signature: _____ Date: _____/_____/_____

Reviewed and entered by Staff Member: _____