

Heights Pediatrics

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Patients Full Name: _____

Female Male Date of Birth: ____/____/____ Hospital Delivered: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Home Phone: (____)____-____

Race: _____ Language: _____ Ethnicity: _____

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

Cell Phone: (____)____-____ Work Phone: (____)____-____

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

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

Cell Phone: (____)____-____ Work Phone: (____)____-____

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

Emergency Contact: _____ Phone: (____)____-____

Insurance Carrier: _____ ID# _____ Group# _____

Policy Holder: _____ Relationship to Patient: _____ SS# _____

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

Did your child receive Hepatitis B in the hospital? _____

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: _____