HEIGHTS PEDIATRICS

Dr. Katerina Silverblatt, Dr. Maria Beatriz Maidana Moreno

Patients Full Name: _____

Female ☐ Male ☐ Date of Birth: ____/____/____

Address: _____ Apt#: _____

City:_____ State:_____Zip Code:_____

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

Hospital where child was delivered: _____

Parents Name: _____ Date of Birth:____/____/____

Cell Phone: (_____)_____-_____ Work Phone:(_____)_____-_____

Social Security: ____-____-_____ E-mail for Patient Portal:_____

Parents Name: _____ Date of Birth:____/____/____

Cell Phone: (_____)_____-_____ Work Phone:(_____)_____-_____

Social Security: ____-____-_____ E-mail for Patient Portal:_____

Insurance Carrier: _____Member#: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security: ____-____-_____

Name & Number of Pharmacy to send all prescriptions to:

_____, (_____)_____-_____, Zip Code: _____

◯ **Consent to permit certain individuals 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.)

Name(s):_____

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

☐ Immunizations ☐ Lab Orders ☐ X-rays ☐ In House

◯ **ONLY Parent/Guardian may accompany children for Treatment** (DO NOT authorize anyone other than the child(ren)'s father, mother, and/or guardian to accompany my child(ren).)

◯ **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 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 application. We **do not** take AMERICAN EXPRESS or DISCOVER.

Mastercard ☐ **Visa** ☐

Cardholder Name _____Cardholder Signature: _____

Credit/Debit Card Number: _ _ _ _ - _ _ _ _ - _ _ _ _-_ _ _ _

Expiration Date: _____/_____ V-Code:_____ Zip: _____

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

*Please provide copy of immunization records and insurance card

Parent's Signature: _____ Date: ____/____/____

Reviewed and entered by Staff Member: _____