# INTAKE FORM - Welcome!

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**Patient's Full Name:** _____ Date of Birth: _____/_____/_____
☐ Female ☐ Male Hospital Delivered: _____ Did your child receive HepB in the hospital? _____
Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
Language: _____ Race: _____ Ethnicity: ☐Hispanic ☐Not Hispanic ☐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: _____-_____-_____
Address (if different from primary address): _____

**Emergency Contact (other than parents):** _____ Phone: (_____)_____-_____
**Preferred Pharmacy:** _____ Phone: (_____)_____-_____ Zip Code: _____

**Insurance Carrier:** _____ ID# _____ Group# _____
Policy Holder: _____ Relationship to Patient: _____ SS# _____

**CONSENT TO TREAT:** ☐ **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): _____

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

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

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT HEIGHTS PEDIATRICS, P.C. [13 YEARS AND OLDER]**

(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.)

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. Please select: ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER
Cardholder Name: _____ Cardholder Signature: _____
Credit/Debit Card Number: _ _ _ _- _ _ _ _- _ _ _ _- _ _ _ _ Exp Date: ____/____ VCode:_____ Zip: _____

By signing, I agree that I've received a paper copy of the Privacy Practices Notice (HIPAA), Financial Policy, and Consent to Treat. I also consent to receiving text messages for recalls (charges may apply from your phone provider). ☐Decline texts

**Parent Signature:** _____
**Date:** _____/_____/_____ Reviewed & Entered by Staff Member: _____