

PEDIATRIC CONSULTANTS, P.C.

ACCT # _____

CHART # _____

DATE _____

PREFERRED LANGUAGE _____

PATIENT INFORMATION

PATIENT NAME _____ SEX _____ SSN _____

PATIENT BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

EMERGENCY CONTACT NAME _____

PHONE _____ RELATIONSHIP _____

NOTE: The following classifications for race / ethnicity are as specified by the US Government. Please circle any and all that apply.

RACE: Black / African American Asian
Native Hawaiian / other Pacific Islander Hispanic / Latino
Alaskan Native White
Native American

ETHNICITY: Hispanic / Latino NOT Hispanic / Latino

RESPONSIBLE PARTY INFORMATION

FATHER / LEGAL GUARDIAN MOTHER / LEGAL GUARDIAN

NAME _____ NAME _____

BIRTHDATE _____ SSN _____ BIRTHDATE _____ SSN _____

ADDRESS _____ ADDRESS _____

CITY _____ ST _____ ZIP _____ CITY _____ ST _____ ZIP _____

EMPLOYED BY _____ EMPLOYED BY _____
(Full Time, Part Time, None) (Full Time, Part Time, None)

WORK ADDRESS _____ WORK ADDRESS _____

CITY _____ ST _____ ZIP _____ CITY _____ ST _____ ZIP _____

WORK PHONE _____ WORK PHONE _____

CELL PHONE _____ CELL PHONE _____

SEPARATED / DIVORCED FAMILIES:

For those families where parents are separated or divorced, the parent who brings the child in to be seen and authorizes treatment is responsible to us for payment. All payments are due when service is rendered. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the responsibility of the authorizing parent to collect payment from the other parent. Pediatric Consultants, PC will not act as mediator in collecting our payments. If the account is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.

SIGNED _____ DATE _____

PLEASE COMPLETE FRONT AND BACK OF THIS FORM.

PEDIATRIC CONSULTANTS, P.C.

ACCT # _____ CHART # _____

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INSURANCE INFORMATION
(We require a copy of your insurance card.)

PRIMARY INS. CO. _____ SECONDARY INS. CO. _____

POLICYHOLDER _____ POLICYHOLDER _____

DATE OF BIRTH _____ DATE OF BIRTH _____

DOES YOUR CHILD HAVE ARKANSAS MEDICAID, MISSISSIPPI MEDICAID, AMERICHoice TENNCARE, BLUECARE, OR TENNCARE SELECT?

Please circle: YES NO

IF YES, PLEASE SPECIFY WHICH ONE: _____

IF YES, IS YOUR CHILD COVERED BY ANY OTHER INSURANCE?

Please circle: YES NO INS _____

ASSIGNMENT AND RELEASE:

I hereby authorize Pediatric Consultants, PC to treat my child, and to furnish information to insurance carriers concerning treatment, and I hereby assign to the doctor all insurance benefits otherwise payable to me for these services. I realize that I am responsible for all charges not covered by my insurance. I also understand that I am responsible for charges (including collection fees/court costs) incurred for this account due to my nondisclosure of all insurance coverage, my failure to update changes to my insurance to allow for timely filing, or my failure to pay in a timely manner. I will also pay any fees charged by the bank for returned checks on this account.

SIGNED _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT:

I hereby acknowledge that I have received the Notice of Privacy Practices of Pediatric Consultants, P.C. I understand this notice contains information regarding how Pediatric Consultants uses my child's medical information.

SIGNED _____ DATE: _____