TODAY'S DATE: ________________

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION:

Child's Name:_________________________ DOB:_____________ M / F Patient Cell # (16yr & ↑):__________________

Race: ___ Asian ____ Black/African American ____ White ____ Other: (Specify) _______________________________

Ethnicity: ____ Hispanic ____ Non-Hispanic ___ Central American ____ Latin American ____ South American
____ Cuban ____ Dominican ___ Puerto Rican ____ Other: (Specify))________________________________

Language: ____ English ____ Spanish ___ Other: (Specify) _________________________________

Emergency Contact: ____________________________ Phone #: _________________ Relationship to Patient: __________________

PARENT / LEGAL GUARDIAN #1 - *LIVING IN SAME HOUSEHOLD AS PATIENTS & PRIMARY CONTACT FOR APPOINTMENT REMINDERS

Name: ______________________________ DOB: ____________ Relationship to Patient:_____________________

Address: _______________________________________ City / State / Zip: ________________________________

☐ Cell ☐ Home ☐ Cell ☐ Home
Primary Phone #:___________________ ☐ Other________ Alternate Phone #:__________________ ☐ Other _______

Occupation: ___________________________________ Employer: _____________________________________

Email: __________________________________ ☐ I agree to receive email & text notifications from The Pediatric Care Ctr

PARENT / LEGAL GUARDIAN #2

Name: ______________________________ DOB: ____________ Relationship to Patient:_____________________

Address: _______________________________________ City / State / Zip: ________________________________

☐ Cell ☐ Home ☐ Cell ☐ Home
Primary Phone #:___________________ ☐ Other________ Alternate Phone #:__________________ ☐ Other _______

Occupation: ___________________________________ Employer: _____________________________________

Email: __________________________________ ☐ I agree to receive email & text notifications from The Pediatric Care Ctr

PARENTS / LEGAL GUARDIANS (please circle) : Married Living Together Single Widowed Separated Divorced

If Divorced or Separated, who is the Custodial Parent? ____

**PLEASE NOTE*: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS.*

PRIMARY INSURANCE: Billing Address & Responsible Party for Billing Issues: ✈ Parent/Guardian #1 ✈ Parent/Guardian #2

Plan Name: ________________________________ ID #: ___________________________ Effective Date:_____________

Subscriber: ___________________________ Subscriber DOB: ___________ Relationship to Patient: ________________

SECONDARY INSURANCE INFORMATION (if applicable):

Plan Name: ________________________________ ID #: ___________________________ Effective Date:_____________

Subscriber: ___________________________ Subscriber DOB: ___________ Relationship to Patient: ________________

PHARMACY:

Pharmacy: ________________________ Phone: ________________ Fax: _________________

SCHOOL:

School: __________________________ Phone: ______________ Fax: _________________

BILLING:

The Pediatric Care Center will submit medical claims to the insurance company based on information I have provided. I understand that I am responsible for updating insurance information each time services are rendered. If this insurance information is not correct, I understand that I will be responsible for any charges. Self-Pay and any Co-Payments MUST BE PAID AT CHECK IN FOR ANY APOINTMENTS. I further understand that The Pediatric Care Center has privacy policies and financial policies in place. I have been offered the opportunity to read and receive a copy of The Pediatric Care Center Notice of Privacy Practices and Financial Policy.

Parent/Legal Guardian Signature:______________________________ **Relationship to Patient**:________________________ Date:__________

PATIENT HIPAA AWARENESS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to

PATIENT HIPAA AWARENESS

With my permission, The Pediatric Care Center may use or disclose my **Protected Health Information** (PHI) about me to carry out **Treatment, Payment & Healthcare Operation** (TPO).

I have the right to review the **NOTICE OF PRIVACY PRACTICES (Below)** prior to signing this consent. I may obtain a copy (upon request) of the **NOTICE OF PRIVACY PRACTICES**. The Pediatric Care Center has the right to revise its **NOTICE OF PRIVACY PRACTICES** at any time. A revised **NOTICE OF PRIVACY PRACTICES** may be obtained upon request.

With my permission, the office and staff of The Pediatric Care Center or Athena may call my home or other designated locations and contacts listed in the patient's chart and leave a message on my voicemail or in person in reference to any items that assist the practice in caring out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others.

With my permission, the office and staff of The Pediatric Care Center or Athena may email or text my home or other designated locations and contacts listed in the patient's chart and leave a message on my voicemail or in person in reference to any items that assist the practice in caring out TPO, such as appointment reminders and patient statements. I have the right to request that The Pediatric Care Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this agreement, I am allowing The Pediatric Care Center to use and disclose my or my child(ren(s)) PHI for TPO.

I may revoke my consent (in writing) except to the extent that the practice had already made disclosures in reliance upon my prior consent.

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I hereby acknowledge that The Pediatric Care Center has allowed me to review and offered to provide me with a copy of its Notice of Privacy Practices. This document describes how medical information about me or my child(ren) may be used and disclosed. It also describes how I may access this information, and the release of information.

Patient Name: _________________________ Signature: ___________________________

Legal Guardian Name: _________________________ Date: ________________________

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so.

Date:	Employee Name:	____ Patient declined to sign this written acknowledgement. Please Specify: