Summit Pediatrics And Adolescent Medicine

Patient Information Form

Please Print

Child's Last Name_____First Name_____Middle:_____

Nickname_____Date of Birth_____Sex:_____Male_____Female

Race_____Ethnicity_____Patient primarily lives with_____

Address_____City_____State____Zip_____

Primary Phone_____Alternate Phone No. _____

Preferred Pharmacy_____Pharmacy Address_____

Do you authorize sharing of electronic medical records to and from your preferred pharmacy? (please circle) Yes No

Parent/Legal Guardian Information – (for example Father)

Name_____Date of Birth_____Relationship to Pt. _____

Address_____City_____State_____Zip_____
(if unknown, please put "unknown")

Primary Phone No._____ Alternate Phone No. _____

Email address_____ Preferred Communications: ___Phone Call ___Text ____Email

Employer_____Work Phone _____

Occupation_____Social Security No. _____

Parent/Legal Guardian Information – (for example Mother)

Name_____Date of Birth_____Relationship to Pt. _____

Address_____City_____State_____Zip_____
(if unknown, please put "unknown")

Primary Phone No._____ Alternate Phone No. _____

Email address_____ Preferred Communications: ___Phone Call ___Text ____Email

Employer_____Work Phone _____

Occupation_____Social Security No. _____

Sibling Information

Other child(ren) who receive care from our office:

Sibling's Legal Name_____Date of Birth_____Sex : Male Female

Sibling's Legal Name_____Date of Birth_____Sex : Male Female

Sibling's Legal Name_____Date of Birth_____Sex : Male Female

Delegating of Authority to Consent to Authorize Medical Treatment and Immunizations

List the individuals other than a parent/legal guardian that you authorize to consent to medical treatment including the immunization of your child:

Name _____ Relationship _____

Name _____ Relationship _____

X _____ _____

Signature of Parent/Legal Guardian Date

Primary Insurance Information:

Insurance Company_____ Patient ID#_____

Group Name _____ Group ID#_____

Guarantor Name_____ Guarantor SS#_____

Guarantor Date of Birth_____

Secondary Insurance Information:

Insurance Company_____ Patient ID#_____

Group Name _____ Group ID#_____

Guarantor Name_____ Guarantor SS#_____

Guarantor Date of Birth_____

FINANCIAL STATEMENT

I certify that the information on this Patient Information Form is correct. I hereby assign all medical benefits to Summit Pediatrics, LLC, which includes any health plan the Practice is or is not enrolled in; private pay plan; and/or major medical plans I may be a part of, for all professional services rendered to my child. I understand that there might be insurance company plans whereby Summit Pediatrics, LLC providers are not participating in, and as such, my insurance plan will probably process our claim as "out of network".
I understand that I am ultimately responsible for payment for services rendered. I understand and agree that my insurance plan policy is a contract between myself and the insurance company. Consequently, I am responsible for any and all co-pays and/or deductibles at the time of the visit as well as all outstanding balances on my account. After 90 days from the date of service, if Summit Pediatrics, LLC does not receive payment from my insurance company, I understand that I will be responsible for all balances at that time. Should I not have insurance for my child, then "self-pay" arrangements require payment for any and all services rendered at the time of the service.

Signature: _____ Date: _____

Print Name: _____

GUARANTOR: The person signing this form will be noted in our records as the "Guarantor" of the account. As such they will receive financial statements from our office. We understand that parents may have developed financial/legal arrangements regarding responsibility for medical care. We request that those arrangements be coordinated between the parents. Both parents are responsible for any financial balance although we will normally communicate with the Guarantor listed on the account.

I have received a copy of the Revised Notice of Privacy Practices at Summit Pediatrics, LLC.

Signature: _____ Date: _____