PLEASE FILL OUT ALL INFORMATION

CHILDREN **DATE OF BIRTH** **GRADE**

_____

_____

_____

FATHER'S INFORMATION	MOTHER'S INFORMATION
NAME:	**NAME**:
ADDRESS:	**ADDRESS:**
DATE OF BIRTH:	**DATE OF BIRTH**:
PLACE OF BIRTH:	**PLACE OF BIRTH:**
SOCIAL SECURITY #:	**SOCIAL SECURITY #:**
OCCUPATION:	**OCCUPATION:**
EMPLOYER:	**EMPLOYER:**
EMPLOYER ADDRESS:	**EMPLOYER ADDRESS**:
EMAIL ADDRESS:	**EMAIL ADDRESS:**
WORK PHONE:	**WORK PHONE**:
CELL PHONE:	**CELL PHONE:**
HOME PHONE:	**HOME PHONE:**

RACE_____ ETHNICITY_____ LANGUAGE_____

INSURANCE _____ INSURANCE ID# _____

NAME OF PERSON CARRYING INSURANCE _____

_____I HEREBY AUTHORIZE NEGATIVE LAB/XRAY RESULTS TO BE REPORTED TO ME VIA EMAIL

_____I UNDERSTAND THAT MY CHILD WILL RECEIVE THE FOLLOWING IMMUNIZATIONS AS RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS, DIPTHERIA, PERTUSSIS AND TETANUS (DTAP), POLIO VACCINES, MEASLES, MUMPS AND RUBELLA (MMR), HEPB VACCINES, H FLU VACCINE (HIB), VARIVAX, AND PNEUMOCOCCAL VACCINE.

_____I HEREBY AUTHORIZE BILLING VIA ELECTRONIC SUBMISSION AND PAYMENT DIRECTLY TO THE OFFICE FOR PROFESSIONAL SERVICES RENDERED AND I SHALL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO THIS OFFICE. CO-PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT. THE OFFICE RESERVES THE RIGHT TO ADD BILLING CHARGES TO ACCOUNTS AFTER SIXTY DAYS, ANY ACCOUNTS FORWARDED TO COLLECTION SERVICES WILL BE SUBJECTED TO AN ADDITONAL 1/3 CHARGE ADDED TO THE ACCOUNT. I AUTHORIZE THE ATTENDING PHYSICIAN TO RELEASE INFORMATION CONCERNING THE EXAMINATION AND TREATMENT OF MY CHILD (FOR INURANCE PURPOSES ONLY).

_____I AM GRANTING PERMISSION FOR CROWN COLONY PEDIATRICS TO VIEW MY CHILD'S PRESCRIPTION HISTORY FROM EXTERNAL SOURCES.

_____I HAVE RECEIVED YOUR NOTICE OF PRIVACY PRACTICES AND/OR I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

_____I AGREE THAT TELEPHONE MESSAGES REGARDING MY APPOINTMENTS, PRESCRIPTION RENEWALS, LAB RESULTS, AND ALL OTHER PROTECTED HEALTH INFORMATION (PHI), MAY BE LEFT FOR ME ON VOICEMAIL SYSTEMS AND ANSWERING MACHINES AT THE TELEPHONE NUMBERS I PROVIDED TO YOU.

SIGNATURE: _____DATE: _____

(PARENT OR LEGAL GUARDIAN)

EMERGENCY CONTACT NAME: _____TELEPHONE # _____

(OTHER THAN PARENT)

ADDRESS: _____CITY:_____STATE: _____ZIP: _____