PATIENT DEMOGRAPHIC FORM

CHILDREN IN HOUSEHOLD	DATE OF BIRTH	GRADE LEVEL

PARENT/GUARDIAN'S INFORMATION

Name:	Name
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Address	Address:
Email:	Email:
Primary Phone: ☐ Cell ☐ Home Work Phone:	Primary Phone: ☐ Cell ☐ Home Work Phone:
Emergency Contact (cannot be parent)	
Name:	Relationship to Patient:
Primary Phone: ☐ Cell ☐ Home	Secondary Phone: ☐ Cell ☐ Home
Insurance:	Named Insured:
Insurance ID:	

- I HEREBY AUTHORIZE NEGATIVE LAB/XRAY RESULTS TO BE REPORTED TO ME VIA EMAIL/MY CHART
- I UNDERSTAND THAT CROWN COLONY PEDIATRICS BELIEVES STRONGLY IN THE SAFETY AND EFFICACY OF IMMUNIZATIONS AND MY CHILD WILL RECEIVE IMMUNIZATIONS AS RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS. CROWN COLONY PEDIATRICS DOES NOT ACCEPT OR KEEP PATIENTS/FAMILIES WHO REFUSE TO VACCINATE
- I HAVE RECEIVED CROWN COLONY PEDIATRICS IMMUNIZATION SCHEDULE
- 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 AND ANY ACCOUNTS FORWARDED TO COLLECTION SERVICES WILL BE SUBJECTED TO AN ADDITIONAL 1/3 CHARGE ADDED TO THE ACCOUNT. I AUTHORIZE THE ATTENDING PHYSICIAN TO RELEASE INFORMATION CONCERNING THE EXAMINATION AND TREATMENT OF MY CHILD (FOR INSURANCE 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 REFILLS, 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
- I UNDERSTAND AND AGREE THAT **ONLY A PARENT OR LEGAL GUARDIAN CAN ACCOMPANY MY CHILD TO THEIR PHYSICALS/ANNUAL WELL VISITS**

By Signing below, you agree to the above statements:

Signature of Parent/Guardian: _____ Date: _____