

PLEASE COMPLETE IN FULL PATIENT DATA SHEET

PATIENT NAME: _____
Last First Middle

Address: _____ Date of Birth: _____

City/State/Zip Code: _____ Social Security #: _____

Telephone Number: _____ Male _____ Female _____

MOTHER'S NAME: _____
Last First Middle

Address: If same check: _____ Street/PO Box: _____

Home Telephone: _____ City/State/Zip: _____

Date of Birth: _____ Social Security #: _____ Cell # _____

E-Mail _____ Employer Name: _____

Work Number: _____ Employer Address: _____

Cell #: _____

Employer Phone: _____ Position: _____

FATHER'S NAME: _____
Last First Middle

Address: If same check: _____ Street/PO Box: _____

Home Telephone: _____ City/State/Zip: _____

Date of Birth: _____ Social Security #: _____ Cell # _____

E-Mail _____ Employer Name: _____

Work Number: _____ Employer address: _____

Cell #: _____

Employer Phone: _____ Position: _____

LEGAL GUARDIAN (if other than parent): _____
Last First Middle

Address: If same check: _____ Street Address: _____

Home Telephone: _____ City/State/ Zip: _____

E-Mail: _____ Employer Name: _____

Date of Birth: _____ Social Security #: _____

Work Number: _____ Employer Name: _____

Person who has physical legal custody? _____ If guardian, do you have legal papers? _____

Preferred Pharmacy: Name: _____ Location: _____ Telephone#: _____

EMERGENCY COVERAGE

The following individuals have permission to seek medical treatment for _____

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

OTHER CHILDREN

Name: _____ Age _____ Name: _____ Age: _____

Name: _____ Age _____ Name: _____ Age: _____

INSURANCE:

Insurance Name: _____ Co Pay _____ Insurance Name: _____ Co Pay _____

Policy Holder/Relationship _____ Policy Holder/Relationship _____

Group #: _____ Policy #: _____ Group#: _____ Policy#: _____

Effective Date: _____ Effective Date: _____

PLEASE SEE NEXT PAGE: MUST BE COMPLETED IN FULL ON A YEARLY BASIS

I/We give permission for Hamblen Pediatric Associates, Inc to treat _____, HPA is also authorized to give DTaP, Pevnar, Hib, Hep B Varicella Menactra MMR Influenza Hep A or any immunizations that are FDA and ACIP approved and endorsed by the AAP as needed

I/We authorize the release of all medical records to insurance companies that the above child is insured by for the purpose of claim payment or referral request. I/we also authorize the release of medical records to any physician or entity to whom _____ is referred I/We understand that HPA cannot be held responsible for the release of medical records after they are copied and sent to another physician or entity which treats _____.

_____ I/we authorize HPA to transmit electronically any prescription that may be prescribed by a Provider of HPA. This may be transmitted by fax or electronically

_____ I/we authorize direct payment by the insurance company directly to Hamblen Pediatric Associates Inc

I/ We understand that insurance is filed as a courtesy. I/We agree to be responsible for all payment to Hamblen Pediatric Associates, Inc I/We further understand that there will be a billing fee added to the visit if co-payment is not made on the day of service, if we have not met our deductible on the date of service and do not pay or for any reason I/We do not make a payment as required by our insurance carrier. I/We also will be responsible for all collection and/or legal fees that HPA may incur in the collection of any outstanding balance that I/We owe.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

HPA use only: chart # _____

New Patient: _____

Reviewed by: _____

Updated Information: _____