

CONFIDENTIAL – PATIENT INFORMATION SHEET / CONSENT FORM

Patient _____ Nickname _____

Male Female Birth Date _____ Age _____ Home Phone # _____

Address _____ City _____ Zip Code _____

Child lives with: Mother Father Both Guardian/Foster Parent

Guardian/Mother’s Name _____ Cell # _____ EMAIL _____

Guardian/Father’s Name _____ Cell # _____ EMAIL _____

Responsible Party _____ Relationship _____

Address _____ Phone # _____

Insurance Information

Patient does not have medical insurance

Name of Insured (Subscriber) _____

Insured’s Birthdate _____ Soc. Sec. # _____

Insured’s Employer _____ Employer’s Address _____

Insur. I.D.# _____ Group/Policy# _____

Additional Insurance _____

CONSENT FOR TREATMENT: I hereby authorize medical treatment for the above named child. I authorize emergency medical treatment for the above named child, in the event, that he/she is brought into this medical practice by any person other than myself.

_____ Initials

AUTHORIZATION AND RELEASE:

I hereby acknowledge that I have received a copy of this medical practice’s HIPAA-Notice of Privacy Practices. I further acknowledge that a copy of the current notice is made available/posted in the waiting area, and that I will be offered a copy of any amended notice of Privacy Practices at each appointment.

_____ Initials

I hereby authorize Pediatric Partners to access medication history, without limitation or exclusion, as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view the patient’s medication.

_____ Initials

I hereby authorize and request my insurance company to pay directly to the physician benefits otherwise payable to me. I understand that my medical insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

_____ Initials

Emergency Contact Information

(OTHER THAN PARENT/GUARDIAN)

(this is not a 3rd Party Auth to Treat – Please complete additional form):

Name _____ Relationship _____

Address _____ Phone # _____

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____ Relationship: _____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 www.mbc.ca.gov