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PATIENT INFORMATION SHEET

TODAY'S DATE ____/____/_____

PATIENT_____ _____ _____ _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ GENDER_____ PHONE_____CELL/LANDLINE

MAILING ADDRESS _____

CITY _____ STATE_____ZIP _____

PROVIDE ANY CURRENT CUSTODY ORDERS (IF APPLICABLE)

RACE/ETHNICITY SELECT ALL THAT APPLY

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Decline
- ☐ Hispanic/Latin/Spanish Origin

PATIENT PRIMARILY LIVES WITH:

- ☐ BOTH PARENTS
- ☐ MOTHER
- ☐ FATHER
- ☐ GUARDIAN
- ☐ GRANDPARENT
- ☐ FOSTER PARENT

PREFERRED LANGUAGE: IS A TRANSLATOR REQUIRED? YES / NO

APPOINTMENT INFORMATION / MEDICAL INFORMATION

MAY WE LEAVE A MESSAGE ON HOME PHONE? (Including auto call)	YES / NO	YES / NO
MAY WE LEAVE A MESSAGE ON CELL PHONE? (Including auto call)	YES / NO	YES / NO
MAY WE SEND TEXT MESSAGES ON CELL PHONE? (Including auto call)	YES / NO	YES / NO
MAY WE LEAVE A MESSAGE ON OFFICE VOICE?	YES / NO	YES / NO
MAY WE LEAVE A MESSAGE WITH ANOTHER PERSON	YES / NO	YES / NO
SEND INFORMATION VIA REGULAR MAIL?	YES / NO	YES / NO
SEND INFORMATION VIA E-MAIL/PATIENT PORTAL?	YES / NO	YES / NO

ELECTRONIC SIGNATURES WILL BE CAPTURED AT THE TIME OF YOUR CHILD'S OFFICE APPOINTMENT, VERIFYING THE INFORMATION ABOVE AND THE STATEMENTS BELOW.

INSURANCE-AUTHORIZATION TO PAY BENEFITS: THIS IS AN AGREEMENT TO BE SIGNED AT THE TIME SERVICES ARE RENDERED. IF YOUR INSURANCE IS NOT VALID OR THE SERIVCE/IMMUNZATION IS DENIED OR NOT COVERED BY YOUR ISURANCE YOU WILL BE CHARGED AS A PRIVATE PAY PATIENT AS PER OUR FINANCIAL AGREEMENT, WHICH IS AVAILABLE TO YOU IN THE WAITING AREA.

PAYMENT AGREEMENT: WESTSIDE PEDIATRICS WILL USE ANY/ALL PHONE NUMBERS LISTED TO CONTACT YOU IN REGARD TO ACCOUNT BALANCES, INCLUDING CELL PHONE NUMBERS.

INSURANCE-RELEASE: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND THE RELEASE OF THE INFORMATION BAK TO MY PHYSICIAN. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE STATED PHYSICIAN(S) FOR SERVICES RENDERED.

PRIVACY POLICY: I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE PRACTICE'S PRIVACY NOTICE AND IF I SO CHOOSE, A COPY WILL BE GIVEN TO ME. (Copies are available in the waiting areas and on our website.)

PARENT / LEGAL GUARDIAN'S INFORMATION

NAME _____ _____ _____ _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ RACE _____ PHONE_____CELL

GENDER_____ ALTERNATE PHONE_____HOME / WORK / OTHER

MAILING ADDRESS(if different than patient)_____

CITY _____ STATE _____ ZIP _____

EMPLOYER_____

EMAIL (to be web enabled)_____

PARENT / LEGAL GUARDIAN'S INFORMATION

NAME _____ _____ _____ _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ RACE _____ PHONE_____CELL

GENDER_____ ALTERNATE PHONE_____HOME / WORK / OTHER

MAILING ADDRESS(if different than patient)_____

CITY _____ STATE _____ ZIP _____

EMPLOYER_____

EMAIL (to be web enabled)_____

MANY OF OUR FAMILIES ARE EXPERIENCING DIFFICULTY IN SOME OF THE FOLLOWING AREAS. PLEASE CHECK OFF ANY OF THE AREAS YOU WOULD LIKE TO SPEAK WITH SOMEONE ABOUT.

___FOOD INSECURITY ___HOUSING PROBLEMS ___TRANSPORTATION ISSUES ___CONCERNS WITH HEALTH INSURANCE

HIPAA (PRIVACY NOTICE):

OTHER AUTHORIZED ALTERNATE CONTACTS, LISTED BELOW (*STEP-PARENT, GRAND PARENT, AUNT, UNCLE*).
MOTHER AND FATHER ARE AUTOMATICALLY CONSIDERED AUTHORIZED FOR ANYONE UNDER THE AGE OF 18.

NAME _____ RELATIONSHIP_____ PHONE_____

ADDRESS_____CITY_____ ZIP_____

NAME _____ RELATIONSHIP_____ PHONE_____

ADDRESS_____CITY_____ ZIP_____

NAME _____ RELATIONSHIP_____ PHONE_____

ADDRESS_____ CITY_____ ZIP_____