**PATIENT INFORMATION SHEET**

**TODAY’S DATE** \_\_\_\_\_\_\_\_\_\_\_\_

PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL/LANDLINE

MAILING ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEX AT BIRTH:** MALE / FEMALE **GENDER IDENTITY:** \_\_\_MALE \_\_\_FEMALE \_\_\_TRANSGENDER MALE \_\_\_TRANSGENDER FEMALE

 \_\_\_NOT SURE/QUESTIONING \_\_\_OTHER: (PLEASE SPECIFY)\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRONOUN:** \_\_\_HE \_\_\_SHE \_\_\_THEY \_\_\_WE \_\_\_DECLINE TO SPECIFY

**PROVIDE ANY CURRENT CUSTODY ORDERS (IF APPLICABLE)**

**PATIENT PRIMARILY LIVES WITH:** \_\_SELF \_\_BOTH PARENTS \_\_MOTHER \_\_FATHER \_\_GRANDPARENT

 \_\_FOSTER PARENT \_\_GUARDIAN

**RACE/ETHNICITY (SELECT ALL THAT APPLY):**

\_\_AMERICAN INDIAN/ALASKAN NATIVE \_\_ASIAN \_\_WHITE \_\_BLACK/AFRIAN AMERICAN \_\_NATIVE HAWAIIAN/PACIFIC ISLANDER

\_\_HISPANIC/LATIN/SPANISH ORIGIN \_\_DECLINE TO SPECIFY

**PREFERRED LANGUAGE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **IS TRANSLATOR REQUIRED?** YES / NO

MANY OF OUR PATIENTS/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

 \_\_OTHER (PLEASE SPECIFY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/LEGAL GUARDIAN INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST FIRST MI PREFERRED TO BE CALLED

DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER \_\_\_\_\_\_\_\_ RACE \_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL/LANDLINE

MAILING ADDRESS (if different than patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER \_\_\_\_\_\_\_\_ RACE \_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL/LANDLINE

MAILING ADDRESS (if different than patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

See Reverse Side

**HIPAA (PRIVACY NOTICE)**

**MOTHER AND FATHER ARE AUTOMATICALLY CONSIDERED AUTHORIZED FOR ANYONE UNDER THE AGE OF 18.**

OTHER AUTHORIZED ALTERNATE CONTACTS LISTED BELOW (MOTHER, FATHER, STEP-PARENT, GRANDPARENT, AUNT, UNCLE, SISTER, BROTHER)

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BY CHECKING THIS BOX YOU ARE GIVING WPG CONSENT TO SPEAK TO THE CONTACT AVOVE ABOUT YOUR PERSONAL INFOMRAITON.

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BY CHECKING THIS BOX YOU ARE GIVING WPG CONSENT TO SPEAK TO THE CONTACT AVOVE ABOUT YOUR PERSONAL INFOMRAITON.

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BY CHECKING THIS BOX YOU ARE GIVING WPG CONSENT TO SPEAK TO THE CONTACT AVOVE ABOUT YOUR PERSONAL INFOMRAITON.

 **Appointment information Medical Information**

May we leave message on home phone? Yes / No Yes / No

May we leave message on cell phone? Yes / No Yes / No

May we send text messages on cell phone? Yes / No Yes / No

May we leave message on office Voice? Yes / No Yes / No

May we leave message with another person? Yes / No Yes / No

Send information via regular mail? Yes / No Yes / No

Send information via e-mail? Yes / No Yes / No

**Electronic signatures will be captured at the time of your child’s office appointment, verifying the above information as well as the statement below.**

This is an agreement to be signed prior to the rendering of services. If your insurance is not valid or the service/immunization is denied or not covered by your insurance, you will be charged as a private pay patient as per our financial agreement available to you in the waiting areas. Should you not have insurance, according to the no surprise medical bill act, you will be provided a “Good Faith Estimate” for potential services rendered.

Balance due, Westside Pediatric Group will use any/all phone numbers listed to contact you in regard to account balances, including cell phone numbers.

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician. I also authorize payment of medical benefits to the above stated physician for services rendered.

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 available in the waiting areas and on our website.)

Created 09/10/15

Updated 6/2023