FALMOUTH PEDIATRIC ASSOCIATES, LLP

GW ACCT.#_____

MM ACCT.#_____

CHILD'S NAME:_____ DATE OF BIRTH: _____ SEX: _____

MAILING ADDRESS: _____ HOME PHONE: _____

CITY: _____ PATIENT PHONE: _____

STATE, ZIP _____ PATIENT PRIMARY LANGUARE: _____

PREFERRED COMMUNICATION: (please circle) E-MAIL HOME CELL TEXT

PATIENT LIVES WITH: (please circle) Both Parents Mother Father Other _____

PATIENT'S RACE: (please circle) White Black Asian Native American Other _____

PATIENT'S ETHNICITY: (please circle) Hispanic/Latino Non-Hispanic/Latino Declined Unknown

MOTHER'S NAME: _____ DOB:_____ CELL: _____

HOME ADDRESS: (if different)_____ WORK :_____

E-MAIL: _____

FATHER'S NAME: _____ DOB:_____ CELL: _____

HOME ADDRESS: (if different) _____ WORK: _____

E-MAIL: _____

PREFERRED PHARMACY: _____ LOCATIONS: _____

EMERGENCY CONTACT: (other than parent) _____

Relationship to patient: _____ PHONE: _____

SIBLINGS NAMES: _____ _____

_____ _____

PRIMARY INSURANCE: _____ POLICY # _____ COPAY: _____

SUBSCRIBER:_____ SUBSCRIBER DOB: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ POLICY # _____ COPAY: _____

SUBSCRIBER:_____ SUBSCRIBER DOB: _____ RELATIONSHIP TO PATIENT: _____

CHILD'S PRIMARY CARE PHYSICIAN: (listed with insurance....please circle one)

PARKINSON LIND O'CONNELL OTHER:_____

BRAMBLEBUSH PEDIATRICS (Primary Doctors Name Required) _____

CAPE COD PEDIATRICS:_____

I have read/received a copy of Falmouth Pediatric Associates HIPAA: _____

(Signature of Self/Parent or Legal Guardian) DATE

Your signature below authorizes the Doctors to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the payment portion at the time of service.

_____

(Signature of Self/Parent or Legal Guardian) DATE

IN THE EVENT THAT CONSENT IS NOT GIVEN TO ANY OR ALL OF THE FOLLOWING CONSENTS PLEASE INDICATE BY ENTERING N/A (non-applicable) IN PLACE OF SIGNATURE

CONSENT FOR RELEASE OF INFORMATION

In the course of caring for your child, it is quite common for others to request health information in order to make this easier, while still maintaining privacy, we ask you to complete the following form.
I, _____, as the parent/legal guardian (circle one) of _____
DOB: _____, give permission to Falmouth Pediatric Associate, LLP to release written and/or verbal information from my child's medical record to the people/organizations mentioned below:

Relatives: _____

_____

School/Daycare/Pre-School/Other: _____

I realize this consent will not extend to psychiatric information or HIV status without separate consent. The duration of this consent will be unlimited, but I may revoke it in writing at any time.

Parent/Legal Guardian Signature: _____ Date: _____

CONSENT FOR MEDICAL VISIT WITH "NON-PARENT" GUARDIAN

I, _____ give permission to the following people to accompany my child to Falmouth Pediatric, LLP for well child and sick visits. I give _____ permission to consent to medical decision making in my absence including but not limited to rapid strep throat test, flu tests, urinalysis, phlebotomy, x-rays, etc. as well as vaccines and prescription medications.

Parent/Legal Guardian Signature: _____ Date: _____

GUARDIAN PERMISSION FOR UNACCOMPANIED TEEN VISITS

I, _____as the parent/legal guardian of _____DOB:_____ give permission for my son/daughter who is a minor under 18 years of age to be seen at Falmouth Pediatrics unaccompanied by a legal guardian. I understand that this permission includes consent to allow my child to be examined and asked about his/her health history without my presence. I also will allow my child to consent to medical decision making, while at Falmouth Pediatrics including but not limited to: rapid strep throat test, flu tests, urinalysis, phlebotomy, x-rays, vaccines etc. My child is also allowed to accept treatments both given in the office and as a prescription to take home as deemed necessary by a physician. I am aware that by signing this form I am allowing my child to consent to medical history taking, examination, testing and treatment as deemed necessary by a physician without the physical presence or verbal consent of a parent/legal guardian on the day of the actual visit.

Parent/Legal Guardian Signature: _____ Date: _____