

UNIVERSITY PLACE PEDIATRIC CLINIC

Account updated by _____
Date entered _____

PATIENT INFORMATION

Male Female

Name _____

First Middle Last

Address _____

Street P.O. Box

City State Zip

Home Phone _____ Patient cell phone _____

Birthdate _____ Age _____ SSN _____

MOTHER'S NAME

(custodial parent? yes no)

Name _____

First Middle Last

Address _____

Street P.O. Box

City State Zip

Home Phone _____ Cell Phone _____

Employer Name _____

Work Phone _____ (ok to call? yes no)

Stepfather's Name _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____

Subscriber Name _____

First Middle Last

Insured ID# _____ Group# _____

Birthdate _____ Employer _____

Patient Relationship to Insured Party _____

Names of siblings _____

PHARMACY INFORMATION

Name _____

Location _____

Phone# _____

PHYSICIAN

Bruce Davies, MD Paul DeBusschere, MD

John Hautala, MD Belinda Rone, MD Megan Struthers, MD

Child resides with: Mother Father Both

Foster Parent Grandparent Other _____

Childs school _____

Grade _____ Phone _____

City _____ District _____

FATHER'S NAME

(custodial parent? yes no)

Name _____

First Middle Last

Address _____

Street P.O. Box

City State Zip

Home Phone _____ Cell Phone _____

Employer Name _____

Work Phone _____ (ok to call? yes no)

Stepmother's Name _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____

Subscriber Name _____

First Middle Last

Insured ID# _____ Group# _____

Birthdate _____ Employer _____

Patient Relationship to Insured Party _____

Who may we thank for referring you to our office?

EMERGENCY CONTACT INFORMATION

Name _____

Home Phone _____ Cell Phone _____

Relationship _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, NOTICE OF PRIVACY PRACTICES

I authorize my insurance benefits to be paid directly to **UNIVERSITY PLACE PEDIATRIC CLINIC** for services rendered. I also authorize **UNIVERSITY PLACE PEDIATRIC CLINIC** to release any information requested by the insurance company with regard to payment of benefits. I acknowledge financial responsibility for all charges relating to my care at **UNIVERSITY PLACE PEDIATRIC CLINIC** that are not covered by insurance. I understand that I may be billed directly from other lab and/or x-ray facilities for charges incurred for diagnostic services. I consent to treatment of the patient above as deemed necessary and appropriate by the attending physician.

CREDIT POLICY: All charges are due within 30 days of the date of service unless prior arrangements have been made. Co-payments are due at time of service. The custodial parent or guardian is responsible for all services rendered. A service charge of 1.5% or a minimum of \$3.00 will be assessed on all account balances of 60 days or older.

NOTICE OF PRIVACY PRACTICES: We keep a record of all services provided to each patient. You may ask to see and request a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information by contacting our Records Custodian. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature, I acknowledge the **Notice of Privacy Practices** has been made available to me.

Signature of Responsible Party

Relationship to Patient

Date signed