Demographic Form 2019

List ALL of your children:

Name: **DOB:** / / **M** **F** **Race**

(last name), (first name), (middle Initial) mm/dd/yyyy

Name: **DOB:** / / **M** **F** **Race**

(last name), (first name), (middle Initial) mm/dd/yyyy

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(last name), (first name), (middle Initial) mm/dd/yyyy

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(last name), (first name), (middle Initial) mm/dd/yyyy

Name: **DOB:** / / **M** **F** **Race**

(last name), (first name), (middle Initial) mm/dd/yyyy

Patients Home Address:

Address Apt#

City State Zip Code Phone #

Parents Information:

Mother's Name/Legal Guardian Date of Birth: / /

Social Security: Email Address:

Home Phone: Cell Phone: Work Phone:

Employers Information:

Company Name: Phone number:

Address Apt#

City State Zip Code Phone #

Father's Name/Legal Guardian Date of Birth: / /

Social Security: Email Address:

Home Phone: Cell Phone: Work Phone:

Employers Information:

Company Name: Phone number:

Address Apt#

City State Zip Code Phone #

If Parents are divorced or separated Please fill out this section:

Name of person who has custody: ______

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **YES** **NO**

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Pharmacy Information:

Pharmacy: Phone Number:

Address: City/State/Zip:

____I give permission to Dekalb Pediatric Associates to retrieve my child's pharmacy medication history

Insurance Information: If you have private insurance, Please Indicate who is the policy holder: Mother____Father_____

Primary Insurance:____Phone Number:_____________________________

Address:____City/State/Zip:_____________________________

ID number:____Group Number:__________________________________

Relationship to Patient:____________________________________Co-Pay Amount:____________________________

Secondary Insurance:___________________________________Phone Number:____________________________
Address:____City/State/Zip:______________________________
ID number:______________________________________Group Number:__________________________________
Relationship to Patient:____________________________Co-Pay Amount:_________________________________

Name of person responsible for Billing Statements:____

I have received a copy of the New HIPPA Policies updated September 2018 and Financial Policy. Initial_______
I certify that my child/children does not have any Health Coverage other than what has been provided. Initial_______
I agree to have my child/children's picture taken as part of their Medical Records. Initial_______

Consent for Treatment:

I hereby authorize Dekalb Pediatrics Associates, P.C. to provide medical care and to administer such treatment as deemed necessary or advisable to me or the named patient each time I visit this office for services. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available. I acknowledge that no guarantee or assurances have been made to me concerning the results intended for my child/children's treatment. Initial __________

Release Of Information:

I permit Dekalb Pediatric Associates, P.C. to disclose all or part of the above patients' information to any insurance company, corporation, or agency when required for collection of benefit payments. Initial ___________

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Insurance and Financial Responsibility:

Physician Statement

In many cases, your insurance company will limit payment of service due to the limitation of your policy. If your insurance company does not pay for a service due to policy limitation, you are financially responsible for the payment of that service.

Beneficiary Agreement

I understand that in some cases, certain services will be denied payment from my insurance company doe to limitations of my personal policy. In the case, that my insurance company denies payment for service. Initial__________

Communications:

I understand that Dekalb Pediatric Associates, P.C. will need to communicate with me at times regarding my child/children's healthcare. By supplying a cell phone number for text messaging and an email address for communicating messages I am giving consent for sed communications.

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Cell Phone E-mail

Care Quality:

We have access to electronic medical records. By Initialing you give permission for Dekalb Pediatric Associates, P.C. to obtain and document your electronic medical records from other facilities in the Care Quality network. Initial__________

Signing below indicates you have accurately completed the form to the best of your knowledge and understand all patient responsibility requirements.

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(signature) (relationship to patient) (date)