Admin/Update

Pediatric Consultants of Troy

Child's Full Legal Name _____ Date of Birth _____

Address where child resides _____ Sex of child F / M

City/State/Zip _____

E-mail _____ Consent to patient portal Y / N

Best number to reach during the day _____ Consent to text Y / N

Race _____ Ethnicity _____ Preferred Language _____

Father's Name _____ Date of Birth _____

Address (if different than child) _____ City/State/Zip _____

Home # _____ Cell # _____ Consent to text Y / N

Mother's Name _____ Date of Birth _____

Address (if different than child) _____ City/State/Zip _____

Home # _____ Cell # _____ Consent to text Y / N

Primary Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Member ID # _____ Group # _____ Office Copay $_____

Relationship to Patient _____ Social Security # _____

Secondary Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Member ID # _____ Group # _____ Office Copay $_____

Relationship to Patient _____ Social Security # _____

Responsible billing party (please circle one) **Mother / Father**

Emergency Contact (other than parent)

Name _____ Phone # _____ Relationship _____

Please list all siblings that pertain to the above information

	Patient Name	Sex	Date of Birth	Insurance
1.	_____	F / M	_____	_____
2.	_____	F / M	_____	_____
3.	_____	F / M	_____	_____
4.	_____	F / M	_____	_____

Pediatric Consultants of Troy

For HIPAA purposes; please list below all children that are patients of Pediatric Consultants of Troy

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Acknowledgement and Authorization

- I have read and understand the HIPPA/Privacy Policy (posted by check-in window)
- I assign my insurance benefits to be paid directly to the healthcare provider
- I authorize to release medical information required to process my claim(s)
- I have read and understand the Financial Policy
- I authorize to obtain/have access to my medication history
- I authorize my providers office to contact me by mobile phone
- A **$25.00 fee will be applied** for any scheduled appointment that is cancelled within 24 hours OR you fail to show for your scheduled appointment

In addition, if in the event Pediatric Consultants of Troy does not receive any payment from the insurance company, it is understood that the undersigned will pay in the full amount upon receipt of statement, whether by mail or in person

- Do we have permission to leave a message with abnormal laboratory results on an answering machine, voicemail or with a family member? Y / N
- Do we have permission to leave a detailed message Y / N

Please list the name(s) and relationship of the person(s) we may leave medical information with about your child(s) health. If you are the age of 18 and older please be sure to list your parent's names below, otherwise we will not have authorization to contact them.

Contact Name _____ Phone # _____ Relationship _____

Contact Name _____ Phone # _____ Relationship _____

Legal Signature _____ Date _____

(If insured is a minor, parent or guardian signature)