Office Use Only

Pt #: _____

PATIENT INFORMATION

First Name	Middle Name	Last Name	Sex	DOB	SS #	*Hispanic or Latino?	Race** (circle one or more)
						Y/N/D	N/W/A/B/HP/D
						Y/N/D	N/W/A/B/HP/D
						Y/N/D	N/W/A/B/HP/D
						Y/N/D	N/W/A/B/HP/D

*Hispanic or Latino: Y=Yes; N=No; D=Decline to answer
**Race: N=Native American; W=White; A=Asian; B=Black; HP=Hawaiian/Pacific Islander; D=Decline to answer

PARENT/LEGAL GUARDIAN CONTACT INFORMATION

***please provide any/all legal documents regarding custody**

NAME_____Relationship (circle) Mother Father Legal Guardian Step-Parent

DOB _____SSN_____Cell_____/_____/_____ Home/Wk_____/_____/_____

Email _____Address _____
Street City State Zip Child's primary address? Y/N

Employer/Occupation_____

NAME_____Relationship (circle) Mother Father Legal Guardian Step-Parent

DOB _____SSN_____Cell_____/_____/_____ Home/Wk_____/_____/_____

Email _____Address _____
Street City State Zip Child's primary address? Y/N

Employer/Occupation_____

EMERGENY CONTACT_____ Relation to patient_____PHONE_____

Child's Insurance/Policyholder Name_____ID_____GRP _____

PARENTS DIVORCED/SEPARATED PLEASE FILL OUT THIS SECTION

- Do parents have joint legal authority over child? Y / N
- Are there any legal restrictions of non-custodial parent from consenting to medical treatment/obtaining treatment info? Y / N **** IF YES, EXPLAIN BELOW AND PROVIDE COPY OF ANY LEGAL RESTRICTION****

  _____

ACKNOWLEDGEMENT OF PRACTICE POLICIES AND PROCEDURES

*****AVAILABLE TO REVIEW AT THE FRONT DESK*****

- **I hereby authorize release of any medical information necessary to process insurance claims for my child, and furthermore assign, transfer and set out to Hometown Pediatrics, all my rights, title and interest to my medical reimbursement benefits under my insurance policy.**
- **I have reviewed or had the opportunity to review a copy of Hometown Pediatrics' Notice of Privacy Practices, Appointment Policy and Billing/Insurance Policy.**

SIGNED_____**DATE**_____

By signing this form, I agree to the policies and procedures above

Consent for Treatment

We realize that the parents or legal guardians of a child may not always be available to bring the child into the office themselves. Children under the age of 17 cannot be treated without a parent or legal guardian or representative present or legal authority and consent granted for another person to bring them.

If a parent or legal guardian cannot be present, anyone on this form is authorized to consent for treatment. This form must be completed by the parent or legal guardian.

I, _____, as parent or legal guardian of give my consent for the following people to authorize treatment of my child(ren) at Hometown Pediatrics. This document will remain valid unless the office is notified in writing of any changes.

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:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

Authorized Person	Relationship to Child(ren)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Parent or legal guardian: _____Date: _____