Last Name	M	First 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
						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

Preferred Language_____

Mom's Name_____Mom's SS_____ Biological/Step/Adoptive/Foster/Legal Guardian

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

*Mom's Email _____Employer_____Cell____/____/____ Home/Wk___/____/____

*****WE WILL SEND ALL BILLING STATEMENTS TO THE EMAIL LISTED ABOVE*****

Dad's Name_____ Dad's SS_____Biological/Step/Adoptive/Foster/Legal Guardian

Dad's DOB _____ Address _____
Street City State Zip Child's primary address? Y/N

Dad's Email _____ Employer_____ Cell ____/____/____ Home/Wk ____/____/____

Child's Insurance/Policyholder Name_____ID_____GRP _____

EMERGENY CONTACT_____PHONE_____

****** PARENTS DIVORCED/SEPARATED PLEASE FILL OUT THIS SECTION******

- **Who has custody/physical guardianship?_____**
- **Any legal restrictions of non-custodial parent from consenting medical treatment/obtaining treatment info? Y / N *IF YES, EXPLAIN AND PROVIDE COPY OF ANY LEGAL RESTRICTION.***

_____

- **Do parents have joint legal authority over child? Y / N**
  If no, specify which child/children this parent *DOES NOT HAVE* legal authority over.

_____

INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

- **I hereby authorize release 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. Initial_____**
- **I have received a copy of Hometown Pediatrics' notice of privacy practices/appointment policy. (Available in our lobby.) Initial_____**

Date_____Signed_____