Office Use Only

Pt #: _____

Last Name	Middle Name	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

Mom's Name_____ Mom's SSN_____ 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___/____/_____

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 ____/____/_____

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**
- **Who has custody/physical guardianship?** _____
- **Are there any legal restrictions of non-custodial parent from consenting to medical treatment/obtaining treatment info? Y / N**

****** IF YES, EXPLAIN AND PROVIDE COPY OF ANY LEGAL RESTRICTION.***

_____

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 TO REVIEW AT THE FRONT DESK) Initial_____**

Date_____Signed_____