Dr. Q Pediatrics

Patient Information Today's Date: _____

Last _____ First _____ Middle _____

Birth Date ___ / ___ / ___ Sex: M ☐ F ☐ SSN# _____ Driver's License # _____

Race: White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Not Provided ☐

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Provided ☐ Language: _____

Address _____ _____ _____ Apt. # _____

City _____ State _____ Zip _____

How were you referred to Dr. Q Pediatrics? _____

Siblings

Last _____First _____ Middle_____ Birth Date ___ / ___ / ___

Last _____First _____ Middle_____ Birth Date ___ / ___ / ___

Last _____First _____ Middle_____ Birth Date ___ / ___ / ___

Last _____First _____ Middle_____ Birth Date ___ / ___ / ___

Primary Guardian Information

Last _____ First _____ Middle _____

Relationship to Patient _____ Birth Date ___ / ___ / ___ Sex: M☐ F☐ SSN# _____

Address: Same as Patient Y ☐ N☐

Address _____ _____ _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail (1) _____

Preferred method of contact to confirm appointments: Phone (home ☐ cell ☐) Email ☐ Text Msg ☐ (Number :____)

Employer _____ Work Phone _____

Secondary Guardian Information

Last _____ First _____ Middle _____

Relationship to Patient _____ Birth Date ___ / ___ / ___ Sex: M☐ F☐ SSN# _____

Address: Same as Patient Y ☐ N☐

Address _____ _____ _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail (1) _____

Preferred method of contact to confirm appointments: Phone (home ☐ cell ☐) Email ☐ Text Msg ☐ (Number :____)

Employer _____ Work Phone _____

Emergency Contact (1)

Last _____ First _____ Middle _____

Relationship to Patient _____ Authorized to Consent to Child's Treatment: Y ☐ N ☐ (attach Consent form)

Address _____ _____ _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Emergency Contact (2)

Last _____ First _____ Middle _____

Relationship to Patient _____ Authorized to Consent to Child's Treatment: Y ☐ N ☐ (attach Consent form)

Address _____ _____ _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Primary Insurance Company

Name _____ Subscriber _____

Subscriber Birth Date ___ / ___ / ___ Relationship to Patient _____ Effective Date ___ / ___ / ___

SS # or ID # _____ Group # _____

Secondary Insurance Company

Name _____ Subscriber _____

Subscriber Birth Date ___ / ___ / ___ Relationship to Patient _____ Effective Date ___ / ___ / ___

SS # or ID # _____ Group # _____

Pharmacy Information:

Name: _____ Phone: _____

Address _____ City _____ State _____ Zip _____

Pharmacy Authorization:

By signing this consent form you are agreeing that Dr Q Pediatrics can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment and payment

purposes. Understanding all of the above, I hereby provide informed consent to Dr Q Pediatrics to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature _____ Date_____

AUTHORIZATION AND CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY

I hereby authorize Dr Q Pediatrics to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign Dr Q Pediatrics all payments to which I am entitled for medical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of visit will result in additional charges. I have received a copy of the current Notice of Privacy Practices.

Signature _____ Date_____