Associates in Pediatric and Adolescent Medicine

PARENT/GUARDIAN INFORMATION

PATIENT'S NAME (First, Middle, Last): ____Sex M F DOB: _________

Mailing Address: ____
City: ___________________________________ State: _________ Zip Code: ___________________

Best phone number to reach patient: ____

Father's Name: (last) ____ Phone # _________________________________
First: __________________________________ Middle Initial _______ Alternate Phone # ________________________
Address (if different from patient) ____
City/State/Zip ____
Email: ____ Date of Birth: ______________________________
Employer: _______________________________________ Social Security #: __________________________

Mother's Name: (last) ____ Phone # __________________________________
First: __________________________________ Middle Initial ________ Alternate Phone # _________________________
Address (if different from patient) ____
City/State/Zip ____
****Email**l: ____ Date of Birth: ______________________
Employer: _______________________________________ Social Security #: __________________________

Marital Status of Parents**:** **__ Married** **__Divorced** **__ Single** **__ other: ______________**
IF NOT MARRIED, Who Has Custodial Rights**: __ Mother ONLY __ Father ONLY __Both __Other: _________________**

Children **(LIST ONLY IF THEY ARE PATIENTS HERE)**

Name: Last		First	Middle	Date of Birth	Sex (M /F)
1.	________________________	____________________	______________	_________________	________
2.	________________________	____________________	______________	_________________	________
3.	________________________	____________________	______________	_________________	________
4.	________________________	____________________	______________	_________________	________

Emergency Contact Name: ___________________________ Relationship: _______________ Phone: ___________________
(Other than Mom or Dad)

GUARANTOR

By signing below, I authorize the release of any medical information necessary to process all claims. I hereby authorize Associates in Pediatric and Adolescent Medicine to apply for benefits on my behalf for covered services. I request payment be made directly to Associates in Pediatric and Adolescent Medicine (Dr.'s Elofson, Fakouri, Perilloux, and Cook). I understand that I am financially responsible for any balance not covered by my insurance.

****** I acknowledge that I have received a copy of the "Notice of Privacy Practices"******

******If the patient's parents/legal guardians are unmarried or legally separated, the parent or guardian who completes this paperwork will be established as the account guarantor. ******

****PAYMENT REQUIRED AT TIME OF SERVICE – UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE****

Date: _________________________________ Print Name: ____
Signature: _______________________________________ Relationship to patient: ______________________________

****YOU MAY OBTAIN A COPY OF OUR FINANCIAL POLICY FROM THE FRONT DESK****

Consent for Secure/Release of Information

I hereby give authorization to Associates in Pediatric and Adolescent Medicine to secure and/or release medical, laboratory, diagnostic, other clinical information and billing information regarding the patient. I understand that this authorization may be revoked in writing at any time.

This authorization applies only to these individuals and institutions. If not completed, no information will be released from our office (with the exception on the insurance and attending healthcare physicians.

Name: ____

Address/Phone: ____

Name: ____

Address/Phone: ____

Name: ____

Address/Phone: ____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposed authorized herein.