GLENDALE PEDIATRICS

(> 18 years of age)

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

DATE : _____/_____/_____

PATIENT INFORMATION:

_____ Date of Birth: ___/___/___ Last 4 # of SSN: _____ Driver Lic # _____

Last name *First Name* *Middle Name* *mm/dd/yyyy*

Primary Address: _____(____)_____

Number *Street* *Apt* *City* *State* *ZIP Code* *Cell Phone Number*

Secondary Address: _____(____)_____

Number *Street* *Apt* *City* *State* *ZIP Code* *Alternate Private Contact Number*

CONTACT INFORMATION: (*Please list contact numbers in order of preference*)

_____(____)_____ ☐ Home ☐ Cell ☐ Work ok to leave message? Y N

Name Relationship Phone Number

_____(____)_____ ☐ Home ☐ Cell ☐ Work ok to leave message? Y N

Name Relationship Phone Number

_____(____)_____ ☐ Home ☐ Cell ☐ Work ok to leave message? Y N

Name Relationship Phone Number

Employer : _____ Occupation : _____

Name City State

School attending (*if applicable*)_____

IN EMERGENCY, NOTIFY: _____ Phone : (____)_____

(*Person not living in the same house*)

Primary Insurance :_____ DOB___/___/___ **Secondary** Insurance :_____ DOB___/___/___

Policy subscriber's name : _____ Policy subscriber's name : _____

Subscriber ID #:_____ Group #:_____ Subscriber ID #:_____ Group #:_____

I hereby assign my insurance benefits to be paid directly to Glendale Pediatrics, A Professional Corporation. I am responsible for informing Glendale Pediatrics of any specific labs, xrays and other ancillary services that my insurance company is contracted with. I am financially responsible for non-covered services, copays and deductibles. I authorize Glendale Pediatrics, A Professional Corporation, to release to my insurance carriers any information required to process my claims.

Signature: _____ Date: _____/_____/_____

PATIENT INFORMATION COMMUNICATION FORM

Family Members / Friends Involved in My Care: Revised Date: _____/_____/_____ Patient Initials:_____

☐ Ok to disclose information about my care or treatment to any individual who states that they are a family member or friend.

☐ Ok to disclose information about my care or treatment to only the following family members or friends (check all that apply):

☐ Mother ☐ Father ☐ Other (*specify by name and relationship*) _____

☐ Do not disclose information about my care or treatment to any individual, regardless of relationship.

Acknowledgement of Receipt of Notice of Privacy Practices: ☐ I have received the Notice of Privacy Practices

Signature: _____ Date: _____/_____/_____

Patient

☐ **Patient refuses, or is unable, to acknowledge receipt of the Notice of Privacy Practices.**

Employee Signature: _____ Date: _____/_____/_____