

**GEORGETOWN PEDIATRICS, P.S.C.  
PATIENT INFORMATION FORM**

<b>PATIENT NAME</b> _____	<b>NAME PATIENT GOES BY</b> _____
<b>DATE OF BIRTH</b> _____ <b>SEX</b> _____	<b>PATIENT SS#</b> _____
<b>SIBLINGS</b> _____	<b>DATE OF BIRTH</b> _____
_____	<b>DATE OF BIRTH</b> _____
_____	<b>DATE OF BIRTH</b> _____

**PARENT OF GUARDIAN INFORMATION**

<b>MOTHER/ OTHER ( )</b>	<b>FATHER/ OTHER ( )</b>
<b>NAME</b> _____	<b>FATHER NAME</b> _____
<b>ADDRESS</b> _____	<b>ADDRESS</b> _____
<b>CITY/STATE/ZIP</b> _____	<b>CITY/STATE/ZIP</b> _____
<b>HOME PHONE</b> _____	<b>HOME PHONE</b> _____
<b>CELL PHONE</b> _____	<b>CELL PHONE</b> _____
<b>E-MAIL ADDRESS</b> _____	<b>E-MAIL ADDRESS</b> _____
<b>SS #</b> _____	<b>SS #</b> _____
<b>DATE OF BIRTH</b> _____	<b>DATE OF BIRTH</b> _____
<b>EMPLOYER</b> _____	<b>EMPLOYER</b> _____
<b>WORK PHONE</b> _____	<b>WORK PHONE</b> _____
<b>PRIMARY RESIDENCE OF PATIENT</b> _____	
<b>CUSTODY INFORMATION</b> _____	
<b>HOW DID YOU HEAR ABOUT US? FAMILY/FRIEND    YELLOW PAGES    INTERNET    OTHER</b> _____	

**EMERGENCY CONTACT (OTHER THAN PARENT)** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

I GIVE PERMISSION FOR THE FOLLOWING PERSON(S) TO BRING MY CHILD TO GEORGETOWN PEDIATRICS IN MY ABSENCE AND TO ACT IN MY BEHALF IN AUTHORIZING MEDICAL CARE AND TREATMENT IN MY ABSENCE OR RECEIVE INFORMATION REGARDING MY CHILD. IN THE EVENT OF EMERGENCY OR OTHER ILLNESS, I UNDERSTAND THAT THE PHYSICIANS/STAFF WILL DELIVER ANY MEDICAL CARE DEEMED NECESSARY REGARDLESS OF THE ACCOMPANYING ADULT. **UNLESS WE ARE NOTIFIED IN WRITING, WE WILL ASSUME THAT A CHILD'S BIOLOGICAL &/OR LEGAL PARENTS ARE BOTH LEGAL GUARDIANS WHO HAVE ACCESS TO TREATMENT OPTIONS AND MEDICAL INFORMATION FOR THAT CHILD.**

<b>NAME</b> _____	<b>RELATIONSHIP</b> _____	<b>PHONE</b> _____
<b>NAME</b> _____	<b>RELATIONSHIP</b> _____	<b>PHONE</b> _____
<b>NAME</b> _____	<b>RELATIONSHIP</b> _____	<b>PHONE</b> _____

*(ANYONE NOT LISTED ABOVE MUST PRESENT WRITTEN AUTHORIZATION FROM THE GUARDIAN BEFORE TREATMENT CAN BE RENDERED.)*

**INSURANCE COMPANY** \_\_\_\_\_ **EFFECTIVE DATE** \_\_\_\_\_

**INSURANCE CLAIMS ADDRESS** \_\_\_\_\_

**INSURED EMPLOYEE'S NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**POLICY GROUP #** \_\_\_\_\_ **ID#** \_\_\_\_\_

**COMPANY NAME** \_\_\_\_\_

**IF HIGH DEDUCTIBLE OR HSA PLAN, WHAT IS THE AMOUNT OF ANNUAL DEDUCTIBLE?** \_\_\_\_\_

I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES RENDERED. I HAVE READ ALL THE INFORMATION AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES.

I HEREBY CONSENT TO GEORGETOWN PEDIATRICS, PSC USING OR DISCLOSING MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF PROVIDING TREATMENT TO ME, OBTAINING PAYMENT FOR HEALTH CARE SERVICES RENDERED TO ME OR TO CARRY OUT THE PRACTICE'S HEALTH CARE OPERATIONS. I ALSO CONSENT TO THE PRACTICE USING OR DISCLOSING PROTECTED HEALTH INFORMATION FOR TREATMENT ACTIVITIES PROVIDED BY ANOTHER HEALTH CARE PROVIDER. I FURTHER CONSENT TO THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION IN ORDER FOR ANOTHER PROVIDER OR HEALTH CARE ENTITY TO CONDUCT HEALTH CARE OPERATIONS INCLUDING QUALITY ASSESSMENT AND REVIEWING THE COMPETENCE OF HEALTH CARE PROFESSIONALS.

I FURTHER ACKNOWLEDGE THE PRACTICE HAS PROVIDED ME A COPY OF ITS NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES A DETAILED DESCRIPTION OF THE USES AND DISCLOSURES ALLOWED BY THIS CONSENT, AS WELL AS OTHER RIGHTS I HAVE REGARDING MY PROTECTED HEALTH INFORMATION.

<b>SIGNATURE</b> _____	<b>DATE</b> _____
<b>PRINTED NAME</b> _____	<b>RELATIONSHIP TO CHILD</b> _____