PEDIATRIC / MINOR PATIENT INFORMATION

BUCKEYE FAMILY HEALTH
Internal Medicine & Pediatrics

LEGAL Name_____
Last First MI

Mailing Address_____
Street City State / Zip Code

Social Security No. _____ Birth Date _____ Age _____

Preferred Telephone (____)_____ Alternate Phone: (____)_____
circle one: home cell work other circle one: home cell work other

Email _____

Sex_____ Race _____ Ethnicity_____
(F) (M) (Hispanic / Non-Hispanic)

Patient Lives With: _____

Patient's Mother's Name _____

Patient's Father's Name _____

EMERGENCY CONTACT - Should be a person <u>NOT</u> living with the patient

Name_____ Relationship _____

Address_____
Street City State / Zip Code

Daytime Telephone (____)_____ Evening Telephone (____)_____

GUARANTOR INFORMATION - Person(s) responsible for payment **other than insurance**

Name_____ Relationship _____

Social Security No. _____ Birth Date_____

Address_____
Street City State / Zip Code

Telephone (____)_____ Occupation _____

Employer Name _____ Employer Telephone No. (____)_____

Employer Address_____
Street City State / Zip Code

- OVER -

Patient Name: **DOB:**

With whom may we discuss patient's medical information (family members, close friends)?

_____

_____

INSURANCE COVERAGE – fill out completely AND provide copy of card(s)

PRIMARY Insurance Company Name _____

Subscriber's Name_____ Subscriber's Birth Date _____

Subscriber Social Security #:_____Subscriber's Phone #: _____

Subscriber's Address: _____

SECONDARY Insurance Company Name _____

Subscriber's Name_____Subscriber's Birth Date _____

Subscriber Social Security #:_____Subscriber's Phone #: _____

Subscriber's Address: _____

I authorize the physicians and staff in attendance on this case to release any necessary personal health information to physicians and other health care organizations to assist with treatment, and to the pertinent insurance company(s) or third party carriers to assist with payment. I understand that I am financially responsible for any balance not covered by the insurance carrier(s). I request that payment of benefits from my policy be paid directly to the billing entity until otherwise notified. I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I authorize Buckeye Family Health to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Signature _____ **Date** _____

Print Name _____

NOTICE RECEIPT ACKNOWLEDGEMENT

I, _____, acknowledge that I have received Buckeye Family Health's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Print **Patient** Name: _____