Pediatrics and Adolescent Medicine, PC

Patient Information Sheet – PLEASE PRINT

Today's Date: _____

Physician: (Circle One) Dr. Wiesner Dr. Robert Dr. Morgan Dr. Salerno Dr. Finn

If you have a primary care physician that is not part of our practice, your visit may not be covered by your insurance plan. Many insurance plans will not cover the cost of a visit if the change to the correct primary care physician is made after the visit. In the event your visit is not covered by your insurance plan, you will be liable for the cost of the visit.

Patient Name: _____ Date of Birth: _____ Patient's Sex: M or F
(Circle One) (First) (Last) (Circle One) (Circle One)

Race: **Patient Declined**
American Indian or Alaskan Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White

Ethnicity: **Patient Declined**
Hispanic or Latino
Not Hispanic or Latino

Country: _____ or USA (Fill in Blank or Circle USA)

Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____

I authorize my health care provider to employ a third-party outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s) and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, other reasonable healthcare related information or to contact the health care provider's office. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, regarding pending appointments, missed appointments and the need to contact the health care provider's office and to leave a message on my voicemail or answering system if I am unavailable at the number provided by me.

Emergency Contact: Name: _____ Phone: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____ Employer: _____

Primary Insurance: _____ Group #: _____ Insurance ID: _____

Guarantor Information: (Person who holds the health insurance that provides coverage for the patient) Relationship to Patient: _____
(Circle One)
Name: _____ Date of Birth: _____ Sex: M or F
(First Name) (Last Name)
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____ Employer: _____

No Show Fee: We will charge a $50.00 fee for an appointment that is missed or canceled less than 24 hours in advance.

Assignment of Benefits - I understand that Pediatrics and Adolescent Medicine, P.C. may obtain information from other physicians/facilities and may release information in the process of obtaining payment from my/my child's insurance carrier. I hereby authorize payment from my/my child's insurance carrier directly to Pediatrics and Adolescent Medicine, P.C. I also acknowledge I am responsible for charges for services rendered that are not covered by my/my child's insurance carrier and payment is due at the time services are rendered. There are over 1,000 health plans in the United States and Pediatrics and Adolescent Medicine, P.C. cannot be responsible for knowing the benefits of all health insurance plans, I acknowledge that I am responsible for understanding the benefits of my/my child's insurance plan. This Assignment of Benefits pertains to all of the children listed on this form.

Siblings who are Patients of our Practice:

(Circle One)
Patient Name: _____ Date of Birth: _____ Patient's Sex: M or F Relationship to Patient: _____
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Patient Name: _____ Date of Birth: _____ Patient's Sex: M or F Relationship to Patient: _____
Patient Name: _____ Date of Birth: _____ Patient's Sex: M or F Relationship to Patient: _____

Preferred Pharmacy: Name: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____ Relationship to Patient: _____

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