Welcome to our clinic!

Please provide the following information on your child.

____
Last First MI

______/______/______ ______________________________ **Sex:** ☐ M ☐ F **RACE:** White / Black / Asian
Date of Birth Social Security Number (Please Circle)

ETHNICITY: ◯ Hispanic ◯ Non-Hispanic ◯ Native American Language Preference: ◯ English ◯ Spanish

Mother:

____
Last First MI

_____/_____/______ ________________________
Date of Birth Social Security Number

Mailing Address: ___________________________________

City, State, ZIP: ___________________________________

Home Phone: ___________________________________

Cell Phone: ___________________________________

Work Phone: ___________________________________

Employer: ___________________________________

Insurance Information:

Carrier Name: ___________________________________

ID#: ___________________________________

Subscriber Name: ___________________________________

Email: ___________________________________

Father:

____
Last First MI

_____/_____/______ ________________________
Date of Birth Social Security Number

Mailing Address: ___________________________________

City, State, ZIP: ___________________________________

Home Phone: ___________________________________

Cell Phone: ___________________________________

Work Phone: ___________________________________

Employer: ___________________________________

Insurance Information:

Carrier Name: ___________________________________

ID#: ___________________________________

Subscriber Name: ___________________________________

Email: ___________________________________

Child lives with: ☐ Mother ☐ Father ☐ Guardian ___________________________________

EMERGENCY CONTACT:

Person: ___________________________ Relationship: ____________________ Phone: ________________

Person: ___________________________ Relationship: ____________________ Phone: ________________

Please complete the following so that we may contact you properly and securely.

- Please list family members or other persons, if any, for whom can bring your child to medical appointments and be informed about your child's general medical condition and diagnosis (including treatment, payment and health care operations.)

Person: ___________________________ Relationship: ____________________ Phone: _______________

Person: ___________________________ Relationship: ____________________ Phone: _______________

- If you would like your billing statement and/or correspondence to be delivered to any other address other than your home, please provide the information for mailing. Do you want mail marked as 'CONFIDENTIAL"? ◯ YES ◯ NO

Address: _____________________________________ City, State, ZIP: __________________________________

Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than you home telephone number. **Please be aware that a cell phone is not a secure, private line.**

Phone 1: ____________________________________ Phone 2: ____________________________________

Authorization of Treatment and Assignment of Benefits:

I authorize Cross Creek Pediatrics, PA to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize direct payment to Cross Creek Pediatrics, PA for all medical/surgical benefits otherwise payable to me under the terms of insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician, is directly exposed to my child's body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C, that I am deemed by law to have consented to testing or infection with HIV or hepatitis B or C viruses. I further understand that by law I have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

_____________________________________ ____________________ ____________________

Parent/Guardian's Signature Relationship Date

NOTES TO US:

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We strive to provide excellent care for our sick and well patients. We believe in the importance of well child care from birth to adolescence and in the prevention of diseases by vaccination. Thank you for the confidence you've placed in us by allowing us to care for your child.