Ambler Pediatrics
Patient Demographic Information

Child #1

_____ _____ _____ _____ _____ Sex: ☐F ☐M _____/_____/_____

Last Name **First Name** **Middle** **Suffix** **Nickname** **Date of Birth**

Race:☐American Indian or Alaskan ☐Asian ☐Black ☐Caucasian ☐Other Pacific Islander **Language:** ☐English ☐Other_____ **Ethnicity**: ☐Hispanic ☐Other

Child #2

_____ _____ _____ _____ _____ Sex: ☐F ☐M _____/_____/_____

Last Name **First Name** **Middle** **Suffix** **Nickname** **Date of Birth**

Race:☐American Indian or Alaskan ☐Asian ☐Black ☐Caucasian ☐Other Pacific Islander **Language:** ☐English ☐Other_____ **Ethnicity**: ☐Hispanic ☐Other

Child #3

_____ _____ _____ _____ _____ Sex: ☐F ☐M _____/_____/_____

Last Name **First Name** **Middle** **Suffix** **Nickname** **Date of Birth**

Race:☐American Indian or Alaskan ☐Asian ☐Black ☐Caucasian ☐Other Pacific Islander **Language:** ☐English ☐Other_____ **Ethnicity**: ☐Hispanic ☐Other

Home Info

_____ _____ _____ (_____)_____

Street Address **Apt #** **P.O. Box** **Primary Phone # Please Circle: Home or Cell**

_____ _____ _____ (_____)_____

City **State** **Zip** **Second Phone # Please Circle: Home or Cell**

Mother's Info

_____ _____

Last Name **First Name**

Address: _____

_____

_____ _____/_____/_____

Social Security # **Date of BIrth**

(____)_____ (____)_____

Cell # **Work #**

Occupation: _____

Father's Info

_____ _____

Last Name **First Name**

Address: _____

_____

_____ _____/_____/_____

Social Security # **Date of BIrth**

(____)_____ (____)_____

Cell # **Work #**

Occupation: _____

Authorize

☐ **I authorize the persons listed below permission to accompany my child to the office and receive medical information pertaining to my child's care**

If you give permission for the persons listed to authorize vaccine administration for your child/children, please indicate below.

Name:_____ ***vaccine- YES***☐ **Relationship to Child**:_____**Phone #**:(_____)_____

Name:_____ ***vaccine- YES***☐ **Relationship to Child**:_____**Phone #**:(_____)_____

Priv acy Notice

The federal Law requires that we make every effort to inform you of your rights related to your personal health information. Please check only one below.

☐Yes, I have read or had explained to me by this office the Notice of Privacy Practices & I wish to continue my care with Ambler Pediatrics under said terms.

☐No, I have not read this office's Notice of Privacy Practices but, I was given the opportunity to read it upfront and declined. I wish to continue my care with Ambler Pediatrics under said terms.

Consent to Leave

If we are unable to speak with you directly, we may need to leave a voice mail/answering machine message or a message with a family member or others who answer your telephone. This message may include detailed information about your child's condition or treatment, such as test results or the scheduling of procedures. Please check one:

☐Yes, you may leave detailed messages at (_____)_____

☐No, DO NOT leave detailed messages, generic messages only

E-Mail

Can we email you reminders for well visits? ☐Yes ☐No

IF YES, email me at:

Pharmac

Please list your preferred Pharmacy Name, Address & Phone # below:

Financial Assignment & Medical Release

☐I authorize Ambler Pediatrics to bill, receive, release and exchange information with my child's insurance company, as well as authorize my insurance company to pay the proceeds of any benefits directly to Ambler Pediatrics.

☐I understand that I am ultimately responsible to know what my insurance will cover and to pay for any denied services.

☐I understand that if I do not pay my balance within 60 days, a 1.50% service fee will be charged to my account, each month, until the account is paid in full.

☐I acknowledge that copays/deductibles/coinsurances are due at the time of service, regardless of who brings my child to the office. If payment is not made at the time of service, a $12.00 service fee will be charged to our account.

☐I acknowledge that if I do not give at least 24 hours notice of cancellation, a $25.00 service fee will be charged to our account for each missed appointment.

☐I certify that the information I furnish is true and correct. I know it is a crime to fill this form with facts I know are false or leave out facts I know are important, and by signing below, I agree to all boxes I checked on this form.

_____

Parent #1 Signature Printed Name

_____

Relationship to Patient Today's Date

_____

Parent #2 Signature Printed Name

_____

Relationship to Patient Today's Date