New Patient Form

Please Complete and Return to Front Desk

after hours pediatrics

Patient Information

Name:_____ Gender:_____ Date of Birth:_____

Address:_____ Apt / Space #:_____

City:_____ State:_____ Zip:_____

Hispanic (circle): Yes / No Mother's Maiden Name: _____

Ethnicity (circle): White Black Native Amer. Asian Multiracial Other _____

Primary Physician Office:_____ Office Phone:_____

If any siblings have been seen at After Hours Pediatrics, list name(s):_____

Responsible Party Information (Parent, Grandparent, Foster Parent, etc.)

Parent/Guardian 1:_____ Gender:_____ Date of Birth:_____

Relationship:_____ Primary Phone: (____) _____ Home / Work / Mobile

Email for parent portal access: _____ ☐ Decline portal

Parent/Guardian 2:_____ Gender:_____ Date of Birth:_____

Relationship:_____ Primary Phone: (____) _____ Home / Work / Mobile

If not responsible party, your name/relationship to patient:_____

Insurance Information (if Medicaid/Centennial, use Patient's name and SSN)

Primary Insurance:_____ Member ID:_____

Policy Holder Name:_____ SSN:_____ Date of Birth:_____

Secondary Insurance:_____ Member ID:_____

Policy Holder Name:_____ SSN:_____ Date of Birth:_____

☐ Billing address same as above

Billing Address: _____ City:_____ State:_____ Zip:_____

Consent and Privacy Information

Initial:_____ I authorize After Hours Pediatrics to treat the forenamed patient in the event of an emergency and after reasonable attempts have been made to contact me.

Initial:_____ I have been provided an opportunity to review and/or receive a copy of the Privacy Policy.

I authorize treatment for the forenamed patient and agree to pay all fees and charges for such treatment. I authorize release of any information required by above-named patient's insurer to process claims for services rendered to patient by After Hours Pediatrics PC and authorize payment of benefits directly to After Hours Pediatrics PC. All charges shown by statement shall be deemed correct and reasonable unless I protest within thirty (30) days of statement date.

Signature of Parent or Guardian: _____ **Date:**_____

OFFICE USE ONLY Teen portal form given or email sent:_____ (initial) Entered by:_____ (initial)