

NORTH BAY PEDIATRICS



PATIENT INFORMATION

DATE: _____

PERSONAL DATA:

CHILD'S NAME: _____
(Last) (First) (Middle)

DOB: _____ SEX: _____ ETHNICITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

PARENT #1 NAME: _____ M/F _____ Date of Birth: _____ SS#: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

PARENT #2 NAME: _____ M/F _____ Date of Birth: _____ SS#: _____

PARENT #2 ADDRESS (IF DIFFERENT THAN ABOVE): _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Child's parents are: Married: _____ Divorced: _____ Never married: _____ Separated: _____ Widow(er): _____ Other: _____

SIBLINGS:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

If child is from a previous relationship:

OTHER PARENT(S) NAME: _____ Date of Birth: _____

Employer : _____ Work Phone: _____

Custody Relationship: _____

EMERGENCY CONTACT: _____ PHONE: _____

INSURANCE INFORMATION:

Name of Insurance Company: _____

Address of Insurance Company: _____

Who is the Policy Holder? _____ DOB: _____

ID #: _____ Group #: _____

OVER →

How or who referred you to our office? _____

- I authorize other medical facilities to release to North Bay Pediatrics any records pertaining to my child or children.
- Payment and co-payments are patients' responsibility and are due at the time of service. ALL CO-PAYS OR PATIENT DUE PORTIONS ARE DUE AT THE TIME OF SERVICE.
- I hereby authorize my insurance benefits to be paid directly to the physician and am financially responsible for any non-covered services. I also authorize the physician to release any information required in the processing of my claims.
- I authorize the physicians from North Bay Pediatrics to examine and administer any necessary treatment to my child or children, and also in the event that I am unavailable.
- I understand that my child will receive a number of vaccines from North Bay Pediatrics as a part of a comprehensive preventative medicine program. These currently include vaccinations for diphtheria, tetanus, pertussis, polio, Hemophilus type B, measles, mumps, rubella, chickenpox, hepatitis A and B, meningococcus, pneumococcus, rotavirus, influenza and human papilloma virus. The risks and benefits of these vaccines are described in detail on the website link www.immunizationinfo.org and can be explained by our physicians during your visits.
- I will allow messages to be left on my voice mail and text messages regarding visits, results and account information.
- I acknowledge that I have received or reviewed a copy of North Bay Pediatrics Privacy Practices* with the effective date September 1, 2013.
- We value you as a patient and want to continue to provide you with high-quality care and service. To do so, we need to set boundaries and expectations that will foster an effective provider-patient relationship. North Bay Pediatrics staff will provide the best possible care for the patient and their family and/or guests. In return, North Bay Pediatrics expects reciprocal behavior from our patients and their family and/or guests. Behavior that is considered rude, threatening, demeaning, or disruptive and which interferes with the staff's ability to provide patient care will result in possible termination of care.

I have read and understand the office policies:

Name of Parent/ Guardian

Signature

E-mail address of custodial parent

Date

* Information provided upon request in office.