HEART TO HEART PEDIATRICS

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME:_____
DATE OF BIRTH _____☐MALE ☐FEMALE
ADDRESS: _____CITY, ZIP_____
PATIENT LIVES WITH ☐MOTHER ☐FATHER ☐BOTH ☐OTHER_____
PHONE# ☐HOME_____☐WORK_____☐CELL _____
(Please check preferred contact number)
PREFERRED LANGUAGE: ☐ENGLISH ☐SPANISH ☐OTHER_____
ETHNICITY: ☐HISPANIC ☐NON HISPANIC ☐OTHER_____
* APA request information on Ethnicity to meet Federal Meaningful use criteria.

PARENT INFORMATION

MOTHER/GUARDIAN LAST NAME: _____FIRST NAME:_____
ADDRESS: _____CITY, ZIP_____
(If different from above)
DATE OF BIRTH: _____EMPLOYER_____EMAIL_____

FATHER/GUARDIAN LAST NAME: _____FIRST NAME: _____
ADDRESS: _____CITY, ZIP_____
(If different from above)
DATE OF BIRTH: _____EMPLOYER_____EMAIL_____

Please list below additional persons who may bring the child to appointments, or who we are authorized to communicate with regarding visits, medical information, etc. Example Step-Parent, Grandparent, Nanny, etc.

NAME: _____RELATIONSHIP_____PHONE#_____
NAME: _____RELATIONSHIP_____PHONE#_____
NAME: _____RELATIONSHIP_____PHONE#_____

INSURANCE INFORMATION (Provide a copy of your insurance Card)

PRIMARY INSURANCE: _____SUBSCRIBER_____
SECONDARY INSURANCE: _____SUBSCRIBER_____

ADDITION FAMILY INFORMATION

OTHER CHILDREN IN THE FAMILY:

NAME: _____DOB:_____ NAME: _____DOB:_____
NAME: _____DOB:_____ NAME: _____DOB:_____
NAME: _____DOB:_____ NAME: _____DOB:_____

CONSENT FOR PAYMENT/ASSIGNMENT OF INSURANCE BENEFITS/ PRIVACY POLICY

- I understand that I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of services or promptly when billed. I understand that **Insurance Card should be presented at EVERY VISIT.**
- I hereby authorized payment of medical benefits directly to Heart to Heart Pediatrics. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.
- Permission to Treat a Minor (Under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Heart to Heart Pediatrics and Associates to treat my child in their office as required by the events of that emergency situation.
- Acknowledgment of Receipt of HIPPA NOTICE OF PRIVACY PRACTICES: I have received, or have been given the opportunity to receive, a copy of **HIPPA Notice of Privacy Practices for Heart to Heart Pediatrics.**

☐ E-Mail Permission: I authorize my e-mail to be used to send practice updates and quarterly newsletters.

_____ _____
Signature Date