PATIENT INFORMATION

***Child's Name:** _____ ***DOB:** _____ ***Sex:** _____

***Address:** _____

***City:** _____ ***State:** _____ ***Zip:** _____

*Language Preference: English Spanish Other_____

*Race: African American Asian Hispanic White Other____

*Ethnicity: Hispanic Non-Hispanic

Siblings and DOB seen here: _____

Biological/Legal
Parent Name_____

DOB_____

Address_____

City_____ State_____ Zip_____

Cell Phone#_____

Email_____

Employer_____

Occupation_____

Biological/Legal
Parent Name_____

DOB_____

Address_____

City_____ _State_____ Zip_

Cell Phone#_____

Email_____

Employer_____

Occupation_____

Step/Co-Parent Information

Name:_____DOB_____

Occupation:_____ Cell Phone#_____

Name:_____DOB_____

Occupation_____ Cell Phone#_____

Parent marital status_____ If single or divorced whom does child live with? _____

In case of an emergency, who should we contact? _____

Contact#_____ Relationship: _____

How did you find our office? _____

PATIENT INSURANCE INFORMATION

If you have Medicaid and **private insurance, BY LAW, Medicaid is always **secondary**. Medicaid **WILL** pay **ALL** fees the private insurance doesn't pay. There will be **NO** out of pocket expense.

****IT IS VERY IMPORTANT TO REPORT ALL INSURANCE COVERAGE TO US & YOUR INSURANCE COMPANIES. IF INSURANCE PAYS ON A CLAIM & LATER FINDS OUT THERE'S OTHER INSURANCE (EVEN IF IT'S SECONDARY) YOU WILL BE RESPONSIBLE FOR THOSE CHARGES. THIS HAPPENS ALL THE TIME & IT MAY BE YEARS LATER. AT THAT POINT IT'S TOO LATE TO FILE A CLAIM WITH THE CORRECT INSURANCE. THE INSURANCE WILL TAKE THE PAYMENT BACK, AND YOU WILL BE REPSONSIBLE FOR ALL CHARGES.**

Primary Insurance Name: _____

Policy Holder: _____DOB: _____

Subscriber/ID_____ Group#_____

Relationship to patient: _____

Secondary Insurance Name: _____

Policy Holder: _____ DOB: _____

Subscriber/ID: _____Group#_____

Relationship to patient: _____

X_____ _____

Signature Date Signed

Printed Name_____

ISLAND PEDIATRICS

CONSENT FOR TREATMENT AND MEDICAL INFORMATION RELEASE FORM

I authorize the examination and treatment of (child's name) _____ by Shelly L. Hall M.D., P.A. (DBA Island Pediatrics) medical staff and such associates they deem necessary. I understand that the examination may include the use of laboratory tests and other non-invasive diagnostic procedures and tests normally provided in a clinic or health facility.

I hereby authorize the health care providers of Island Pediatrics to release and exchange all pertinent medical records regarding my child's treatment to appropriate consulting medical personnel without the necessity of obtaining further permission from me. If I do not authorize the release of this information, I understand the continuity of care could be affected. I agree to assume all responsibility from my refusal to exchange this information and also agree not to hold my physicians or other personnel responsible for any adverse results from my refusal to release this information.

I authorize the release of information for processing health insurance claims, including drug and alcohol use, psychiatric evaluation/treatment and/or AIDS or testing for AIDS (HIV). If I do not consent to the release of this information, I understand that I am personally responsible for all or any part of my bills for treatment.

All medical record information received/released by this office is protected by state and federal confidentiality laws. Any further disclosure of this information is prohibited.

Signature of parent/adult legally responsible for minor child:

X _____

Printed name: _____ Date: _____

Other persons authorized to bring child in for MEDICAL treatment (does NOT include initial visit, well child visits, immunizations, or any other invasive procedures:

Name: _____ Relationship: _____

Name: _____ Relationship: _____