CORNERSTONE PEDIATRICS 2017

PATIENT NAME: _____ Sex: M F Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ SS#: _____

Patient resides with: Mom____ Dad____ Other_____

Please provide qualified domestic relations order for chart if child doesn't reside with both parents

MOTHER'S NAME: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

SS#: _____ Employer: _____ Phone: _____

FATHER'S NAME: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

SS#: _____ Employer: _____ Phone: _____

Please list any Siblings of this Patient who are Current or Former Patients of Cornerstone Pediatrics:_____
_____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#: _____ Employer: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy Number: _____

Employer's Name: _____

Policy Holder: _____ Sex: M F SS#: _____

Date of Birth: _____ Relationship to Child: _____

Insurance Address: _____

Secondary Insurance Name: _____ Policy Number: _____

PLEASE COMPLETE BOTH SIDES OF FORM

Employer's Name: _____

Policy Holder: _____ Sex: M F SS#: _____

Date of Birth: _____ Relationship to Child: _____

Insurance Address: _____

I HEREBY CONSENT TO THE ADMINISTRATION OF SUCH MEDICAL CARE AND TREATMENT AS DETERMINED APPROPRIATE BY CORNERSTONE PEDIATRICS, LLC, FOR THE ABOVE MINOR. I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS FOR CONTINUITY OF CARE OR BILLING PURPOSES. IN ADDITION, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO CORNERSTONE PEDIATRICS, LLC, FOR SERVICES PERFORMED.

Parent's Signature: _____Date_____

Dear Parent or Guardian,

We understand that it is not always possible for you to bring your child to our office for care and that you may wish to send them with family members or close friends. Please take the time to fill out the following form carefully. List the names of those individuals that you will allow to make appointments and/or bring your child to our office for well and sick visits. Please understand that we will not treat your child if he/she is brought to our office with someone other than a parent or guardian unless we get your written permission in advance.

I hereby authorize the following individuals to make appointments and/or bring my child to Cornerstone Pediatrics to receive care from all physicians and staff as needed for sick and well care if I am unable to accompany him/her. I do understand that insurance co-payments or full payment is due at the time of the visit, regardless of who brings the child to the appointment.

Name: _____ Relationship to child:_____

Name: _____ Relationship to child:_____

Name: _____ Relationship to child:_____

Name: _____ Relationship to child:_____

EMERGENCY CONTACT INFORMATION

Please list the name, relationship, and phone number of at least two people <u>not living with you</u> who we may contact in the event of an emergency.

1. Name: _____ Relationship: _____

   Home Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

   Home Phone: _____ Cell Phone: _____

Parent's Signature: _____ Date: _____