GEORGETOWN PEDIATRICS, P.S.C.
PATIENT INFORMATION FORM
(Asterisks indicate required/mandatory fields)

Patient Name:

Last:* ______________ **First:*** ______________ **Middle Initial:*** ____ Suffix: ____

Name child goes by: ______________ **Date of Birth:*** ____ / ____ / ____

Sex:* (circle one) Male / Female **Social Security No.*** ____ - ___ - ____

Address:* ______________ **City:*** ______________ **State:*** ________ **Zip:*** __________

Phone (H):* (____) - ____ - ______ **Phone (C):*** (____) - ____ - ______

Email:* ______________ **Preferred Contact:** Home Phone / Cell / Work / Portal/ Mail

Siblings: ______________ Date of Birth: ______________

______________ Date of Birth: ______________

______________ Date of Birth: ______________

Race:*
___ Asian
___ Black or African American
___ White
___ Other (please specify) ______________

Ethnic Group:*
___ Not Hispanic or Latino
___ Hispanic or Latino

Preferred Language:*
___ English
___ Spanish
___ Other ______________

Primary Provider:*
___ Dr. Horace P. Hambrick
___ Dr. David. M. Hoddy
___ Dr. Kristy K. Menke
___ Dr. Jennifer S. Riebel
___ Dr. Ann N. Quackenbush
___ Dr. Jennifer S. Oliver
___ Dr. Laura A. Forster
___ Dr. Lacey B. Sweigart

PARENT AND/OR GUARDIAN INFORMATION:

Mother Name / Other:* ______________
Marital Status:* ______________
Address:* ______________
City/State/Zip: ______________
Home Phone:* ______________
Cell Phone:* ______________
SSN:* ______________
Date of Birth:* ______________
Employer:* ______________
Work Phone:* ______________

Father Name / Other:* ______________
Marital Status:* ______________
Address:* ______________
City/State/Zip:* ______________
Home Phone:* ______________
Cell Phone:* ______________
SSN:* ______________
Date of Birth:* ______________
Employer:* ______________
Work Phone:* ______________

Who does the patient live with: ______________ **Who has custody of patient:** ______________

EMERGENCY CONTACT

____

Name (other than Parent/Legal Guardian) **Relationship** **Phone Number**

SEE BACK PAGE PLEASE

Is it OK to leave PHI (Protected Health Information) on your voicemail? **Yes** **No**

PRIMARY INSURANCE INFORMATION:

Insurance Company:* ______________________
Effective Date:* ______________________
Insurance Claims Address: ______________________
Policy Holder's Name:* ______________________
Relationship to Patient: ______________________
Policy Holder's DOB:* ______________ Policy Holder's SSN:* ______________
Policy Group #:* ______________ ID #:* ______________
Company Name: ______________________

SECONDARY INSURANCE INFORMATION:

Insurance Company:* ______________________
Effective Date:* ______________________
Insurance Claims Address: ______________________
Policy Holder's Name:* ______________________
Relationship to Patient: ______________________
Policy Holder's DOB:* ______________ Policy Holder's SSN:* ______________
Policy Group #:* ______________ ID #:* ______________
Company Name: ______________________

CONSENT TO TREAT

My signature below hereby authorizes Georgetown Pediatrics, PSC to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Georgetown Pediatrics, PSC. This includes any tests, immunizations, or other procedures which may be deemed advisable or necessary. You will be notified of any such testing and you have the right to an explanation of any procedures and their risks, benefits, alternatives before they occur. My signature consents to these procedures. I understand it is my responsibility to inquire about and/or decline any such procedures if I do not wish them to occur. The occurrence of a procedure indicates that I understand the risks and benefits and I'm satisfied with the explanations provided and/or have asked any questions and I'm satisfied with the response given. To facilitate treatment, I also consent for us to reference an electronic clearinghouse to review medications prescribed, whether prescribed by our office or other providers.

In addition, I authorize the individuals listed below (must be over the age of 18 and provide photo ID) to accompany my child to medical appointments and act on my behalf in authorizing medical care and treatment in my absence. I understand that the signature of the listed individual(s) will obligate me to any applicable charges and is a surrogate for my own signature.

In the event of an emergency or other illness, I understand that the physicians and staff of Georgetown Pediatrics, PSC will deliver any medical care deemed necessary regardless of the accompanying adult. **Unless we are notified in writing by a legal entity, we will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child.**

(Other than Parent/Guardian – Please Print)

***1 - Name:** ______________ **Relationship to Patient:** __________ **Phone:** __________
2 - Name: ______________ **Relationship to Patient:** __________ **Phone:** __________
3 - Name: ______________ **Relationship to Patient:** __________ **Phone:** __________

*****These individuals will not have the authority to sign for release of medical records.*****

I certify that I am the patient/legal guardian of the minor child. The information provided is true and accurate to the best of my knowledge.

______________________ ______________
Patient/Guardian Signature Date

______________________ ______________
Printed Name Relationship to child

rev. 8/19/15