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:** ____________________

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

****SEE BACK PAGE PLEASE****

EMERGENCY CONTACT INFORMATION/OTHER AUTHORIZED ADULTS:

I give permission for the following person(s) to bring my child to Georgetown Pediatrics in my absence and to act in my behalf in authorizing medical care and treatment in my absence or receive information regarding my child. In the event of emergency or other illness, I understand that the physicians/staff 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)*

***1 - Name: ___________________________ Relationship to Patient: _______________ Phone: ____________**
2 - Name: ___________________________ Relationship to Patient: _______________ Phone: ____________
3 - Name: ___________________________ Relationship to Patient: _______________ Phone: ____________

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:

I understand and agree that I am responsible for the balance on my account for any services rendered. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. Thus, I will notify you of any changes. I hereby consent to Georgetown Pediatrics, PSC, using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the practice's health care operations. I also consent to the practice using or disclosing protected health information for treatment activities provided by another health care provider. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

SIGNATURE: ____ DATE: ________________________________

PRINTED NAME: _____________________________________ RELATIONSHIP TO CHILD: ________________