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. Katie Smallwood
___ 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. 1/23/19

How did you hear about us? (please circle one):

Family/Friend Internet Welcome Wagon Yellow Pages Other:_____