Gilbert Pediatrics

*******Please circle your requested PCP******

Dr. Guthrie, Dr. Leavitt, Dr. Carroll, Dr. Jacks, Dr. Tan, Melani, Debbie, Brittany

Child: _____ D.O.B. ___/___/___ Sex [ ]M [ ] F
First Middle Last

Mailing Address: _____
Street or PO Box City State & Zip

Who lives at this household? _____

(Please note, this information is being requested to improve intake of your child's Social History.)

Names of other siblings or foster children living with you:

_____ ___/_____/____[ ]M [ ]F _____ ___/____/____[ ]M [ ]F

_____ ___/_____/____[ ]M [ ]F _____ ___/____/____[ ]M [ ]F

_____ ___/_____/____[ ]M [ ]F _____ ___/____/____[ ]M [ ]F

First Middle Last Date of Birth First Middle Last Date of Birth

Contact Information

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Parent/Guardian: Name: _____

Date of Birth: _____ / _____ / _____ Social Security #: _____/_____/_____

Relation to Patient: Mother/Father/Step-Mother/Step-Father/Foster Parent/Other, please list: _____

Lives with patient? [ ]Y [ ]N If not, please provide address:_____

Home Phone: (___) _____ - _____ Work Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

Preferred Email: _____ Home email / Work email (please circle)

How would this person prefer to be contacted regarding (circle only one on each line):

Medical Issues:	Cell Phone	Email	Home Phone	Work Phone
Appointment Reminders:	Cell Phone	Email	Home Phone	Work Phone
Recall Notices:	Cell phone	Email	Home Phone	Work Phone
General Practice Notices:	Cell Phone	Email	Home Phone	
Patient Portal Notifications:	Cell Phone	Email		

Parent/Guardian: Name: _____

Date of Birth: _____ / _____ / _____ Social Security #: _____/_____/_____

Relation to Patient: Mother/Father/Step-Mother/Step-Father/Foster Parent/Other, please list: _____

Lives with patient? [ ]Y [ ]N If not, please provide address:_____

Home Phone: (___) _____ - _____ Work Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

Preferred Email: _____ Home email / Work email (please circle)

How would this person prefer to be contacted regarding (circle only one on each line):

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Appointment Reminders:	Cell Phone	Email	Home Phone	Work Phone
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General Practice Notices:	Cell Phone	Email	Home Phone	
Patient Portal Notifications:	Cell Phone	Email		

Insurance Information

Primary Policy:

Policy Holder's Name: _____Birth Date: _____ SSN:_____/_____/_____ Sex: [ ]M [ ]F

Insurance Carrier: _____ Policy ID#: _____ Group #:_____

Employer: _____

Secondary Policy:

Policy Holder's Name: _____Birth Date: _____ SSN:_____/____/_____ Sex: [ ]M [ ]F

Insurance Carrier: _____ Policy ID#: _____ Group #:_____

Employer: _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? [ ]Y [ ]N

If no, list who may have access _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? [ ]Y [ ]N

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Primary Language: _____**Ethnicity**: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/Unknown

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Emergency Contacts (other than parents) Authorized to Bring Patients for Services (Age 21 or over):

(initial if authorized to bring child for services)

1: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

2: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

3: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

4: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

5: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

I give my permission for medical treatment of the above-named child/children. I also give permission for the initialed authorized individual(s) above to make decisions regarding treatment, prescriptions and immunizations if I am not available to give my consent. I understand that I am financially responsible for non-covered charges. I hereby assign my insurance benefits to be paid directly to the physician and to release any information necessary to process my claim. I understand that missed appointments result in a $30 no show fee. In the event my account must be placed in collections, I agree to pay the collection fee of 30% of account balance. **I have received Gilbert Pediatrics' Privacy Policy, Vaccine Policy, and Financial Policy.**

Completed by (please print): _____

SIGNATURE_____DATE_____