Gilbert Pediatrics

Guthrie, Leavitt, Auxier, Jaskowiak, Carroll, Howard, Shumway, Jacks, Le Bras

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 First Middle Last

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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Recall Notices:	Cell phone	Email	Home Phone	Work Phone
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 #:______________

Secondary Policy:

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

Insurance Carrier: ___________________ Policy ID#: ______________________ Group #:______________

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.

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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. In the event my account must be placed in collections, I agree to pay collection fee of 30% of account balance. **I have received Gilbert Pediatrics' Privacy Policy, and Financial Policy.**

Completed by (please print): ____

SIGNATURE____DATE_________________________