

CHILDREN IN HOUSEHOLD:

1. _____ M F
last first MI nickname date of birth (mm/dd/yyyy)

2. _____ M F
last first MI nickname date of birth (mm/dd/yyyy)

3. _____ M F
last first MI nickname date of birth (mm/dd/yyyy)

4. _____ M F
last first MI nickname date of birth (mm/dd/yyyy)

CONTACT INFORMATION:

Address: _____
street

_____ city state zip

Home Phone: () -
Fax: () -

_____ family e-mail

GUARDIAN INFORMATION:

Guardian 1: Mother Other _____
relationship

_____ name

_____ social security number _____ date of birth

Phones: h: () - w: () - c: () -

_____ employer _____ occupation

Guardian 2: Father Other _____
relationship

_____ name

_____ social security number _____ date of birth

Phones: h: () - w: () - c: () -

_____ employer _____ occupation

CONSENT TO TREAT:

_____ name _____ relationship to patient

_____ name _____ relationship to patient

What is "Consent to Treat"?
These people have your permission to bring your children to doctor's appointments and make medical decisions in your absence. This permission will remain valid until you notify Potomac Pediatrics in writing.

PREFERRED PHARMACY:

_____ name _____ location

PRIMARY INSURANCE:

_____ insurance company _____ group number _____ ID number

_____ policy holder _____ relationship _____ date of birth

_____ insurance company address

SECONDARY INSURANCE:

_____ insurance company _____ group number _____ ID number

_____ policy holder _____ relationship _____ date of birth

_____ insurance company address

Authorization and Release: I authorize the doctor to release any personally identifiable health care information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers. I understand that this information will be processed through an electronic billing service. I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ signature of patient or parent if patient is a minor _____ date

FOR OFFICE USE ONLY

HIPPA Completed: _____