Patient Information Form
Date:_____

Primary Provider
□ Bonnett, MD
□Shealy, MD
□Johnson, APRN

1.Fullname:_____ Gender:□ M □F
First Middle Last
Date of Birth: _____ SSN:_____

2. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

3. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

4. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

5. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

6. Full name:_____ Gender: □ M □F
First Middle Last
Date of Birth: _____ SSN:_____

Primary Residence Mailing Address:_____

City:_____ State: _____ Zip Code: _____

Primary Phone Number: _____ □ Home □ Cell

- **Race**: □American Indian □Alaskan Native □Asian □ Native Hawaiian □Hispanic
  □Other South Pacific Islander □African American/Black □White □Other
- **Ethnicity**: □Hispanic or Latino □Not Hispanic or Latino
- **Preferred Language**: _____
- **Preferred Notification Method:** □Postal Mail □Telephone □Patient Portal Message
- **Emergency Contact**:
  Name:_____Relationship:_____Phone#_____

****SEE BACK****

Parent/Guardian Information

MOTHER: Full Name: _____ Date of Birth _____

SSN_____Relationship: □Biological □Step □ Foster □ Legal Guardian □ Other_____

Address: □ Same as Child_____City_____ ST_____ Zip_____

Home #_____ Cell # _____

Employer _____ Phone # _____

Email: _____

FATHER: Full Name: _____ Date of Birth _____

SSN_____Relationship: □Biological □ Step □ Foster □ Legal Guardian □ Other_____

Address: □ Same as Child_____City_____ ST_____ Zip_____

Home # _____ Cell # _____

Employer _____ Phone # _____

Email: _____

PATIENT PORTAL: Chapin Pediatrics has a patient portal (FollowMyHealth). Visit (**CHAPINPEDIATRICS.COM)** for details.

If you wish to receive an invite to the patient portal please indicate here: □Mother □Father □Both

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Effective Date: _____	Effective Date: _____
Subscriber Name: _____	Subscriber Name: _____
SS#: _____D.O.B._____	SS#: _____D.O.B._____
Relationship to Patient: _____	Relationship to Patient: _____

Consent For Treatment and Discussion of Information

I authorize the following adults, other than parent or legal guardian listed above, to be involved with the evaluation, management, and discussion of my child's healthcare.

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Consent For Disclosing Protected Health Information (PHI)

SCHOOL/DAYCARE: I authorize Chapin Pediatrics to disclose the following PHI.
_____ *Doctor's Excuse* _____*Immunization Record* _____ *Permission for Medication*
directly to (list schools and/or daycare below) via _____ fax and/or _____ mail:

_____

_____

_____

_____

EMAIL: I authorize Chapin Pediatrics to send the following PHI.
_____ *Doctor's Excuse* _____*Immunization Record* via email.
I understand that email is not a secure method of communication and is not recommended because it increases the risk that an unauthorized person may receive or interpret my child's or children's' protected health information. I release Chapin Pediatrics from any liability for submitting PHI using email upon my verbal request and this signature located on this form below. **_____initial.**

FAX: I authorize Chapin Pediatrics to fax the following PHI.
_____ *Doctor's Excuse* _____*Immunization Record* to my work place (if applicable).
I understand that this is not recommended because it increases the risk that an unauthorized person may receive or interpret my child's or children's' protected health information. I release Chapin Pediatrics from any liability for submitting PHI using my work's fax number upon my verbal request and this signature located on this form below. **_____initial.**

Authorization, Assignment of Benefits and Record Release

I consent to my child's treatment and allow Chapin Pediatrics to use and release their protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Chapin Pediatrics Notice of Privacy Practices. A copy has been made available to me and is also available at www.chapinpediatrics.com.

I understand that my child's medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Chapin Pediatrics for all medical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and noncovered services.

A photocopy of this form shall be considered as effective and as valid as the original.

I know it is my responsibility to keep Chapin Pediatrics informed about changes to any of my contact information. Failure to do so may interfere with the ability to contact me concerning my child's health care.

_____
Print Parent or Legal Guardian's Name

_____ Date_____
Parent or Legal Guardian's Signature