Patient Information Form

Date:_______________

Primary Provider

□ Bonnett, MD
□ Shealy, MD
□ Bolen, MD
□ Johnson, APRN
□ Edwards, 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**:

****SEE BACK****

Name:____________________________Relationship:________________Phone#__________________

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:

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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