DATE / /

DEPENDENT INFORMATION

Father's / Guardian's Name		Father's Social Security #	Father's Date of Birth / /
Father's Home Address Street		City State	Zip
Father's Home Phone # Check box for primary contact # ☐	Father's Cell Phone # Check box for primary contact # ☐	Father's Work Phone #	Primary Language
Father's Employer		Father's Email Address	
Mother's / Guardian's Name	Mother's Maiden Name	Mother's Social Security #	Mother's Date of Birth / /
Mother's Home Address Street		City State	Zip
Mother's Home Phone # Check box for primary contact # ☐	Mother's Cell Phone # Check box for primary contact # ☐	Mother's Work Phone #	Primary Language
Mother's Employer		Mother's Email Address	

Do you have a blended family? Yes: ___ No: ___ If yes, please complete a separate form for each child.

ALL CHILDREN UNDER 18 YEARS - INCLUDING THOSE SEEN TODAY Full Name *(Please Print)* Date of Birth Sex	LIST DEPENDENTS (EACH CHILD'S) ETHNICITY AND RACE:
1. _____ ____ / ____ / ____ M F	**Ethnicity:** ❑ Not Hispanic or Latino ❑ Hispanic or Latino **Race:** ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black ❑ White
2. _____ ____ / ____ / ____ M F	**Ethnicity:** ❑ Not Hispanic or Latino ❑ Hispanic or Latino **Race:** ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black ❑ White
3. _____ ____ / ____ / ____ M F	**Ethnicity:** ❑ Not Hispanic or Latino ❑ Hispanic or Latino **Race:** ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black ❑ White
4. _____ ____ / ____ / ____ M F	**Ethnicity:** ❑ Not Hispanic or Latino ❑ Hispanic or Latino **Race:** ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black ❑ White
5. _____ ____ / ____ / ____ M F	**Ethnicity:** ❑ Not Hispanic or Latino ❑ Hispanic or Latino **Race:** ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black ❑ White
6. _____ ____ / ____ / ____ M F	**Ethnicity:** ❑ Not Hispanic or Latino ❑ Hispanic or Latino **Race:** ❑ American Indian/ Alaskan Native ❑ Asian ❑ Black ❑ White

CHILD/CHILDREN LIVES WITH:

❑ Father & Mother ❑ Father Only ❑ Father - Remarried ❑ Mother Only ❑ Mother - Remarried ❑ Joint Custody ❑ Legal Guardian ❑ Grandparent(s)

Please designate one parent that you would prefer to receive information from our office.

To which phone number would you like your reminder text sent ? _____

❑ Check the Box if you prefer to not receive a text.

Contact privacy constraints: (choose one)

❑ No restriction: OK to leave messages/send mail ❑ Restricted: Person-to person with patient/guardian only.

Nearest Relative other than Parents			Relationship
Relative's Home Address Street		City	State Zip
Relative's Home Phone #	Relative's Cell Phone #		

PLEASE TURN OVER ➔

INSURANCE INFORMATION	
1) Name of Primary Insurance: _____	2) Name of Secondary Insurance: _____
Insurance ID. No. _____ Group No. _____	Insurance ID. No. _____ Group No. _____
Name of Card Holder: _____	Name of Card Holder: _____
Date of Birth: _____/_____/_____	Date of Birth: _____/_____/_____

Preferred Pharmacy: _____
(Name) (Address, City, State)

To divorced parents:

It is our office policy that all correspondence, medical and financial, is sent to one address, usually where the child resides. It is up to the parents to decide how best to communicate between households information and concerns regarding your children. Fees for office visits are due at the time of service. We will not bill separate households for payment. Parents should work out the arrangements between themselves.

REGARDLESS of what your divorce decree states, we are not part of that settlement. This is the only way we can provide quality medical care for your children.

Authorization & Assignment

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim for this child/dependent. My signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, the physician or supplier agrees to accept the charge determination of the insurance company as the full charge, and I am responsible for the deductible, co-pay, co-insurance and non-covered services. **I understand that I am personally responsible for all fees regardless of insurance coverage.** It is customary to pay for services when rendered unless other arrangements have been made in advance with our office.

Signature: _____ **Date:** ____ /____ / ____

Treatment Authorization

Our preference is to always have a parent or guardian on site when treating our patients. However, we realize there are instances when you are unable to accompany your child to their appointment. Please keep in mind, if your child is under the age of 18, they **MUST** have an adult with them **for the entire appointment.**

In case of my absence, I hereby authorize Cereal City Pediatrics providers to provide medical care for my children as deemed necessary. I give permission to have my child/children to be evaluated and treated (Including signing for immunizations) by the medical providers at Cereal City Pediatrics from (date) _____ to (no longer than 12 months from the date of this form). My child could be accompanied to the office by one of the following adults:

Name	Relationship to child
1. _____	
2. _____	
3. _____	

Signature: _____ **Date:** ____ /____ / ____

Thank you for choosing us as your health care provider.

We are committed to provide your child the best treatment possible.