

Jeffers, Mann and Artman Pediatric And Adolescent Medicine, P.A.

Father's Information

Full Name _____
Address _____
Zip Code _____ Home # _____
Work# _____ Cell# _____
Date of Birth _____ SS# _____
Employer Name _____
Occupation _____
Email _____

Child/Patient Information

Last Name _____
First Name _____ Middle Initial _____
Male/Female _____ DOB _____
SS# _____ Language _____
Race _____ Ethnicity _____
Address _____
_____ Zip Code _____
Phone# _____ Cell# _____

Mothers's Information

PT ID# _____

Full Name _____
Address _____
Zip Code _____ Home# _____
Work# _____ Cell# _____
Date of Birth _____ SS# _____
Employer Name _____
Occupation _____
Email _____

Insurance Information

Ins. Co. Name _____
ID# _____
Group# _____ Eff. Date _____
Primary _____ Secondary _____
Policy Holder: _____
Employer: _____
Employer Phone #: _____

Additional Child/Patient on back

Permission to Seek Treatment, Emergency Contacts, Obtain Prescriptions and Medical Forms

In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment, obtain any prescriptions or other medical forms, for myself or my child from Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A. I also realize that the person listed on this form or the person with my child may have access to pertinent protected health information if medically necessary. This authorization will be valid for one year from the date listed below.

Name _____ Phone# _____ Relationship _____

Name _____ Phone# _____ Relationship _____

Signature of Parent/Patient _____ Date _____

Release of Information Other Than Insurance

I the patient/parent/guardian give Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A. and Clayton Pediatric and Adolescent Medicine, P.A. permission to release information to my daycare/school upon request. Ex: Immunization record, dispensing of medication, and or absentee note due to appointment.

Signature of Parent/Patient _____ Date _____

Release of Information To Insurance

I understand that payment in full is expected at the time of service. However, in the event that Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A. files claims on my behalf or my childs, I authorize all benefits to be paid directly to Jeffers, Mann and Artman Pediatric, P.A. Any charges not covered by insurance will be my responsibility.

I authorize Jeffers, Mann and Artman Pediatric and Adolescent Medicine P.A. and/or the rendering physician(s) to release all information required by my insurance company to file for medical benefits.

Signature of Parent/Patient _____ Date _____

The above information within this enclosed box is granted to all children/patients listed on both sides of this form

Employee Completion _____ / _____ Date _____ / _____
PM EHR

PT ID# _____

Child/Patient Information

Last Name _____

First Name _____ Middle Initial _____

Male/Female _____ DOB _____

SS# _____ Language _____

Race _____ Ethnicity _____

Address _____

_____ Zip Code _____

Phone# _____ Cell# _____

Child/Patient Information

Last Name _____

First Name _____ Middle Initial _____

Male/Female _____ DOB _____

SS# _____ Language _____

Race _____ Ethnicity _____

Address _____

_____ Zip Code _____

Phone# _____ Cell# _____

Child/Patient Information

Last Name _____

First Name _____ Middle Initial _____

Male/Female _____ DOB _____

SS# _____ Language _____

Race _____ Ethnicity _____

Address _____

_____ Zip Code _____

Phone# _____ Cell# _____

Child/Patient Information

LastName _____

First Name _____ Middle Initial _____

Male/Female _____ DOB _____

SS# _____ Language _____

Race _____ Ethnicity _____

Address _____

_____ Zip Code _____

Phone# _____ Cell# _____

Child/Patient Information

Last Name _____

First Name _____ Middle Initial _____

Male/Female _____ DOB _____

SS# _____ Language _____

Race _____ Ethnicity _____

Address _____

_____ Zip Code _____

Phone# _____ Cell# _____

Child/Patient Information

Last Name _____

First Name _____ Middle Initial _____

Male/Female _____ DOB _____

SS# _____ Language _____

Race _____ Ethnicity _____

Address _____

_____ Zip Code _____

Phone# _____ Cell# _____

Signature of Parent/Patient _____ Date _____