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

****Child/Patient Information****

Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____Zip Code _____

Gender: (Please Circle) Male Female _____

DOB _____

Primary Contact # _____

Secondary Contact # _____

Preferred Provider/Physician_____

Language _____ Race _____

Patient Email _____

Insurance Information

Primary Ins. Co. Name _____

Ins Address _____

_____

Employer_____

Effective Date _____

Subscriber _____

ID# _____Group # _____

Ethnicity (Please Circle)

Hispanic/Latino Non Hispanic/Latino Declined

Father's Information

Last Name_____ First Name _____ M _____

Address _____

City _____

Zip Code _____ DOB _____

Primary Phone Contact #_____

Secondary #_____Work # _____

Employer Name_____

Occupation_____

Email _____

Mother's Information

Maiden Name _____

Last Name _____ First Name _____ M ____

Address _____

City _____

Zip Code _____ DOB _____

Primary Contact # _____

Secondary # _____Work#_____

Employer Name _____

Occupation _____

Email _____

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 child's, 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 ____

Address _____

City_____ Zip Code _____

Gender:(Please Circle) Male Female

DOB _____

Primary Contact # _____

Preferred Provider/Physician _____

Language _____ Race _____

Ethnicity:(Please circle) Hispanic/Latino Non Hispanic Latino Decline

Patient Email: _____

PT ID#_____

Child/Patient Information

Last Name _____

First Name _____Middle Initial ___

Address _____

City_____ Zip Code _____

Gender:(Please Circle) Male Female

DOB _____

Primary Contact # _____

Preferred Provider/Physician _____

Language _____ Race _____

Ethnicity:(Please circle) Hispanic/Latino Non Hispanic Latino Decline

Patient Email: _____

PT ID#_____

Child/Patient Information

Last Name _____

First Name _____ Middle Initial ___

Address _____

City _____ Zip Code _____

Gender:(Please Circle) Male Female

DOB _____

Primary Contact #_____

Preferred Provider/Physician _____

Language _____ Race _____

Ethnicity:(Please circle)Hispanic/Latino Non Hispanic Latino Decline

Patient Email: _____

PT ID#_____

Child/Patient Information

Last Name _____

First Name _____Middle Initial ___

Address _____

City _____ Zip Code_____

Gender:(Please Circle) Male Female

DOB _____

Primary Contact # _____

Preferred Provider/Physician _____

Language _____ Race _____

Ethnicity:(Please circle) Hispanic/Latino Non Hispanic Latino Decline

Patient Email: _____

Updated 2/19/2015
Revised 6/14/2016