

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

Patient/Child Information

Last Name _____ Home Phone # _____
First Name _____ Middle Initial _____ **Patient** Mobile Phone # _____
Address _____ **Patient** Email _____
City _____ Zip Code _____ Preferred Provider/Physician _____
DOB _____ Gender (Circle) Male Female Primary Ins. Co. Name _____
Patient's Mothers Maiden Name _____ Language _____ Race _____
Ethnicity (Please Circle)
Hispanic/Latino Non-Hispanic/Latino Declined

Siblings at this Address: _____
Name/DOB Name/DOB Name/DOB

Father's Information

Last Name _____ First Name _____ M _____
 Address same as patient
Address _____
City _____
Zip Code _____ DOB _____
Home Phone # _____
Mobile # _____ Work # _____
Employer Name _____
Email _____

Mother's Information

Last Name _____ First Name _____ M _____
 Address same as patient
Address _____
City _____
Zip Code _____ DOB _____
Home Phone # _____
Mobile # _____ Work# _____
Employer Name _____
Email _____

CONSENT OF PARENTS/GUARDIANS OF MINOR PATIENTS

**TO DISCLOSE HEALTH INFORMATION FOR PAYMENT,
TREATMENT AND HEALTH CARE OPERATIONS**

By my signature below, I hereby authorize the Jeffers Mann and Artman Pediatric and Adolescent Medicine, P.A. to disclose my child's medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child, seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment, seek treatment, obtain prescription(s) or other medical forms: (please list only people over the age of 18 and their relationship to the patient. For example: (Tom Jones, grandfather)

None

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

ASSIGNMENT OF INSURANCE BENEFITS

By my signature below, I authorize medical benefits to be paid to Jeffers Mann and Artman Pediatrics and Adolescent Medicine, P. A. on my behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates.

Signature of parent/guardian/personal Relationship to patient Date
representative of minor child

Office Use Only _____
Initial Date