

Demographic Form 2020

List ALL of your children:

Name: _____ **DOB:** _____ **M** **F** **Race** _____
(last name), (first name), (middle Initial)

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(last name), (first name), (middle Initial)

Patients Home Address:

Address _____ Apt# _____
City _____ State _____ Zip Code _____ Phone # _____

Parents Information:

Mother's Name/Legal Guardian _____ **Date of Birth:** _____

Social Security: _____ **Email Address:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Employers Information for Guarantor:

Company Name: _____

Address _____ Apt# _____

City _____ State _____ Zip Code _____ Phone # _____

Father's Name/Legal Guardian _____ **Date of Birth:** _____

Social Security: _____ **Email Address:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

If Parents are divorced or separated Please fill out this section:

Name of person who has custody: _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **YES** **NO** _____

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Pharmacy Information:

Pharmacy: _____ **Phone Number:** _____

Address: _____ **City/State/Zip:** _____

Insurance Information: If you have private insurance, Please Indicate who is the policy holder: Mother ____ Father ____

Primary Insurance: _____ **Phone Number:** _____

Address: _____ **City/State/Zip:** _____

ID number: _____ **Group Number:** _____

Relationship to Patient: _____ **Co-Pay Amount:** _____

Secondary Insurance: _____ **Phone Number:** _____

Address: _____ **City/State/Zip:** _____

ID number: _____ **Group Number:** _____

Relationship to Patient: _____ **Co-Pay Amount:** _____

____ I give permission to Dekalb Pediatric Associates to retrieve my child's pharmacy medication history

Name of person responsible for Billing Statements: _____

I have received a copy of the New HIPPA Policies updated September 2018 and Financial Policy. Initial _____
I certify that my child/children does not have any Health Coverage other than what has been provided. Initial _____
I agree to have my child/children's picture taken as part of their Medical Records. Initial _____

Consent for Treatment:

I hereby authorize Dekalb Pediatrics Associates, P.C. to provide medical care and to administer such treatment as deemed necessary or advisable to me or the named patient each time I visit this office for services. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available. I acknowledge that no guarantee or assurances have been made to me concerning the results intended for my child/children's treatment. Initial _____

Release Of Information:

I permit Dekalb Pediatric Associates, P.C. to disclose all or part of the above patients' information to any insurance company, corporation, or agency when required for collection of benefit payments. Initial _____

Insurance and Financial Responsibility:

Physician Statement

In many cases, your insurance company will limit payment of service due to the limitation of your policy. If your insurance company does not pay for a service due to policy limitation, you are financially responsible for the payment of that service.

Beneficiary Agreement

I understand that in some cases, certain services will be denied payment from my insurance company due to limitations of my personal policy. In the case, that my insurance company denies payment for service, I am assuming responsibility for the bill. Initial _____

Communications:

I understand that Dekalb Pediatric Associates, P.C. will need to communicate with me at times regarding my child/children's healthcare. By supplying a cell phone number for text messaging and an email address for communicating messages I am giving consent for sed communications.

Cell Phone _____ E-mail _____

Do you need a translator? Yes No If Yes what language do you speak _____.

Care Quality:

We have access to electronic medical records. By Initialing you give permission for Dekalb Pediatric Associates, P.C. to obtain and document your electronic medical records from other facilities in the Care Quality network. Initial _____

Signing below indicates you have accurately completed the form to the best of your knowledge and understand all patient responsibility requirements.

(signature) _____ (relationship to patient) _____ (date) _____

Is anyone else, besides the parent allowed to bring your child to his/her appointment? Yes No
If Yes please ask for Additional Consent Form at front desk.