DECERINA UY PEDIATRICS – PATIENT DEMOGRAPHIC

CHILD/CHILDREN INFORMATION - *Any additional children can be written on reverse side*

Child's Name ______________________ DOB: __________ ☐ Male ☐ Female

Child's Name ______________________ DOB: __________ ☐ Male ☐ Female

Child's Name ______________________ DOB: __________ ☐ Male ☐ Female

Child's Name ______________________ DOB: __________ ☐ Male ☐ Female

PARENT / LEGAL GUARDIAN #1 ** LIVING IN THE SAME HOUSEHOLD AS PATIENT(S) & PRIMARY CONTACT*

Name: ______________________ DOB: __________ Relationship to Patient __________

Address: ______________________ City/State/Zip __________

Primary Phone # ______________________ ☐ Cell ☐ Home ☐ Other __________

Alt. Phone # ______________________ ☐ Cell ☐ Home ☐ Other __________

Occupation: ______________________ Employer: __________

Email: ______________________ ☐ I agree to receive email notifications

PARENT / LEGAL GUARDIAN #2

Name: ______________________ DOB: __________ Relationship to Patient __________

Address: ______________________ City/State/Zip __________

Primary Phone # ______________________ ☐ Cell ☐ Home ☐ Other __________

Alt. Phone # ______________________ ☐ Cell ☐ Home ☐ Other __________

Occupation: ______________________ Employer: __________

PARENT/LEGAL GUARDIAN *(please circle one)* Married Living Together Single Widowed Separated Divorced

If Divorced or Separated, who is the Custodial Parent? ______________________

If the Legal Guardian, who is the Legal Guardian and relationship? ______________________

** ***PLEASE NOTE:*** LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS **

INSURANCE -- Billing Address & Responsible Party for Billing Issues ☐ Parent #1 ☐ Parent #2

Plan Name: ______________ ID # ______________ Eff Date __________

Subscriber Name: ______________ Subscriber DOB: __________ Relationship: __________

PHARMACY INFORMATION

Primary Pharmacy ______________ Address ______________ Phone __________

Mail Away Pharm ______________ Address ______________ Phone __________

Decerina Uy Pediatrics will submit medical claims to the insurance company based on information I have provided.
I understand that I am responsible for updating insurance information each time services are rendered.
If this insurance information is not correct, I understand that I will be responsible for any charges.
I further understand that Decerina Uy Pediatrics has privacy policies and office policies in place and I have been offered copies.

Parent/Legal Guardian Signature ______________________ Date: __________

Relationship to Patient ______________________

CHILD/CHILDREN NAMES ______________________________

HIPAA AUTHORIZATION STATEMENT
and
AUTHORIZATION TO ACCOMPANY MINOR(S)

Newborn to Age 17

***** Patients age 18 and older must fill out their own individual HIPAA Form*****

Medical care and immunizations cannot be provided to a minor that is not accompanied by a parent or legal guardian unless permission is granted to another specified adult (18 years or older).
Please list the family members or other person(s) who may accompany your child so we can discuss your child's general medical condition and discuss diagnoses (including treatments, health care concerns and payment.)

Please be aware that any personal information relating to the minor pertinent to the visit may be disclosed.

I (We) hereby authorize:

Name: ______________________ Phone: ________________ Relationship ____________

Name: ______________________ Phone: ________________ Relationship ____________

Name: ______________________ Phone: ________________ Relationship ____________

Name: ______________________ Phone: ________________ Relationship ____________

Name: ______________________ Phone: ________________ Relationship ____________

To accompany my/our child to the office of Decerina Uy MD PC in my absence.
I (We) hereby authorize Decerina Uy and her personnel to deliver medical services to my child.

EMERGENCY CONTACT (Only in the event parent(s) cannot be contacted in the case of dire emergency)

Name: ______________________ Phone: ________________ Relationship to Patient(s) ____________

ASSIGNMENT OF BENEFITS
and
AUTORIZATION OF TREATMENT and CONSENT TO TREAT MINOR

I authorize Decerina Uy MD PC FAAP and her personnel to treat my child. Being the parent/legal guardian of the above minor(s), I consent to the said procedures being performed, whether I am present or not and my signature hereunder, shall be full and sufficient authority.

I hereby request and consent to diagnostic procedures, medical treatments and immunizations deemed advisable by the professional staff of Decerina Uy Pediatrics. I acknowledge that I have read this consent form and understand its contents.

I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment made directly to Decerina Uy MD for all medical or surgical benefits otherwise payable to me the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. I hereby authorize saidassignee to release all information necessary to secure payment.

Print Name ______________________________ **Relationship** ________________

Signature ______________________________ **Date** ________________