Thomasville Pediatrics
Archdale-Trinity Pediatrics
Thomasville-Archdale Pediatrics Well-Child Clinic
Midway Pediatrics

PATIENT INFORMATION

PLEASE FILL OUT EACH LINE ON THE ENTIRE FORM

PATIENT NAME____ (Nickname: ____________________)

Address ____
STREET CITY STATE / ZIP

Date of Birth ____________ Place of Birth ________________________ **BEST PHONE #** ( ) _______ - ________
☐ HOME ☐ WORK ☐ CELL

Sex: (check one) ☐ Male ☐ Female

PLEASE INDICATE THE FOLLOWING FOR THE CHILD:

Race:
☐ W = Caucasian
☐ B = African American
☐ A = Asian
☐ I = American Indian / Native Alaskan
☐ 1 = Black & White
☐ 2 = Asian & White
☐ 3 = Black and Asian
☐ U = Unknown / Refuse to answer

Ethnicity:
☐ H = Hispanic / Latino
☐ N = Non-Hispanic / Non = Latino
☐ U = Unknown / Refuse to answer

Preferred Language:
☐ English ☐ Spanish ☐ Other ________________________

FAMILY INFORMATION:

MOTHER / LEGAL GUARDIAN	**FATHER / LEGAL GUARDIAN**
Name: ____________________________________	Name: ____________________________________
Date of Birth: ____/____/____	Date of Birth: ____/____/____
Mailing Address: ____________________________ STREET	Mailing Address: ____________________________ STREET
____ CITY STATE / ZIP	____ CITY STATE / ZIP
Home Phone (_____) _____ - ________	Home Phone (_____) _____ - ________
Work Phone (_____) _____ - ________	Work Phone (_____) _____ - ________
Cell Phone (_____) _____ - ________	Cell Phone (_____) _____ - ________
Employer: __________________________________	Employer: __________________________________
Email:	Email:

Who is the person responsible for this account? ☐ BOTH ☐ FATHER ☐ MOTHER ☐ OTHER ____________________

INSURANCE INFORMATION: BE AWARE THAT YOU WILL BE ASKED FOR YOUR INSURANCE CARD AT **EVERY** VISIT

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT):

Name: ____ Relationship: ___________________________

Home Phone: __________________ Cell Phone: ___________________ Work Phone: __________________

Signature: __________________________________ Date: ________________

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HIPAA & AUTHORIZATION

PLEASE FILL OUT ACCORDINLGY

PATIENT NAME: ________________________________ DATE OF BIRTH: ________________

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION (PHI):

I hereby give my permission to the person(s) listed below to receive information about the care of the above-named patient:

NAME	RELATIONSHIP TO PATIENT
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PRIMARY INSURANCE:

Insurance Company: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Employer: ______________________________

Name of Policy Holder: ______________________________

SECONDARY INSURANCE:

Insurance Company: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Employer: ______________________________

Name of Policy Holder: ______________________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician designated to release information acquired in the course of the examination and treatment. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number. With my signature on this form, I authorize and consent to the release of my (or my child's) medical records to Thomasville Archdale-Trinity Pediatrics. I understand and agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

AUTHORIZATION FOR PAYMENT: I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I understand that I am financially responsible for charges not covered by my insurance, whether private or Medicaid, and I hereby guarantee timely payment in full for any such charges.

I have read the consent form and the Notice of Privacy Practices and I agree with the terms stated in the notice. Also, I agree that in order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier (Patient's Date of Birth): ________________

Signature of Patient, Parent or Legal Guardian: ________________________________ Date: ________________