FACEY MEDICAL GROUP

An affiliate of PROVIDENCE Health & Services

EMR #: ___________

Pediatric Patient Information Sheet

Date: ____________________

Patient Name: ______________________________ Primary Care Physician (PCP): ____________________

Preferred Name (if any): ______________________________ Date of Birth (mm/dd/yyyy): ___/___/______

Social Security #: _____ ___ ______ Sex: ☐ Female ☐ Male

Street Address (home): ______________________________ Primary Phone Number: ____________________

City: ____________________ State: _____ ZIP: _______

Race (Select one)

☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Hispanic/Latin/Spanish Origin
☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian
☐ Decline to Say

Primary Spoken Language: ____________________

Ethnicity (Select One):

☐ Hispanic/Latin/Spanish Origin
☐ Non-Hispanic/Latin/Spanish Origin
☐ Decline to Say

Parent/legal Guardian Responsible For Patient's Financial Obligations

Parent/Guardian Name: ______________________________ Relationship to Patient: ____________________

Social Security #: _____ ___ ______ Date of Birth (mm/dd/yyyy): ___/___/______

Home Phone: ____________________ Cell Phone: ____________________ Primary Phone: ☐ Home ☐ Cell

Street Address (if different from above): ______________________________

City: ____________________ State: _____ ZIP: _______ Work Phone (incl. any extension): ____________________

Employer Name: ______________________________ City: ____________________ State: _____ ZIP: _______

Parent/Guardian's Preferred Communication Method: ☐ Phone ☐ Mail ☐ Email ____________________ ☐ Do Not Contact

Additional Parent/Guardian & Emergency Contact Information

THIRD PARTY CONSENT ON FILE? ☐ YES ☐ NO

Parent/Guardian Name: ______________________________ Relationship to Patient: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Primary Phone: ☐ Home ☐ Cell

Street Address (if different from above): ______________________________

City: ____________________ State: _____ ZIP: _______ Work Phone (incl. any extension): ____________________

Secondary Contact Name: ______________________________ Relationship to Patient: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Primary Phone: ☐ Home ☐ Cell

Street Address (if different from above): ______________________________

City: ____________________ State: _____ ZIP: _______ Work Phone (incl. any extension): ____________________

Health Insurance Information

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO

Primary Health Insurance

Insurance Company: ____________________

Insurance Phone #: ____________________

Subscriber's Name: ____________________

Subscriber's Employer: ____________________

Subscriber's Date of Birth: ___/___/______

Subscriber's Social Security #: _____ ___ ______

Policy #: ____________________

Group #: ____________________

Effective Date: ___/___/______

Secondary Health Insurance (if any)

Insurance Company: ____________________

Insurance Phone #: ____________________

Subscriber's Name: ____________________

Subscriber's Employer: ____________________

Subscriber's Date of Birth: ___/___/______

Subscriber's Social Security #: _____ ___ ______

Policy #: ____________________

Group #: ____________________

Effective Date: ___/___/______

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payments to **Facey Medical Foundation,** benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this Assignment may be honored.

PARENT/LEGAL GUARDIAN SIGNATURE: ______________________________ DATE: ___/___/______

EMPLOYEE/WITNESS SIGNATURE: ______________________________ DATE: ___/___/______