Gilbert Pediatrics

Guthrie, Leavitt, Auxier, Jaskowiak, Carroll, Howard, Shumway, Jacks, Le Bras
480-892-3880 / 480-545-4551

Child: _____ D.O.B. ___/___/___ Sex [ ]M [ ] F
First Middle Last

Mailing Address: _____
Street or PO Box City State & Zip

Home Phone: _____-_____-_____Who lives at this household?_____

(Please note, this information is being requested to improve intake of your child's Social History.)

Names of other siblings or foster children living with you:

_____/_____/____[ ]M [ ]F _____/____/____[ ]M [ ]F

_____/_____/____[ ]M [ ]F _____/____/____[ ]M [ ]F

_____/_____/____[ ]M [ ]F _____/____/____[ ]M [ ]F

First Middle Last First Middle Last

Primary Language: _____Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/Unknown

Insurance Information

Primary Policy:

Policy Holder's Name: _____Birth Date: _____ SSN:_____/_____/_____ Sex: [ ]M [ ]F

Insurance Carrier: _____ Policy ID#: _____ Group #:_____

Secondary Policy:

Policy Holder's Name: _____Birth Date: _____ SSN:_____/____/_____ Sex: [ ]M [ ]F

Insurance Carrier: _____ Policy ID#: _____ Group #:_____

Contact Information

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? [ ]Y [ ]N Primary phone number: _____ Cell Phone? [ ]Y [ ]N

If contact doesn't live with patient, please provide contact's address:_____

Relation to Patient: Mother/Father/Step-Mother/Step-Father/Foster Parent/Other, please list: _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email / Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle only one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? [ ]Y [ ]N Primary phone number: _____ Cell Phone? [ ]Y [ ]N

If contact doesn't live with patient, please provide contact's address:_____

Relation to Patient: Mother/Father/Step-Mother/Step-Father/Foster Parent/Other, please list: _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email / Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle only one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? [ ]Y [ ]N

If no, list who may have access _____

If parents are divorced or separated please fill out this section:
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? [ ]Y [ ]N

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

_____

Emergency Contacts/Authorized to Bring Patients for Services (Age 21 or over): (initial if authorized to bring child for services)

1: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

2: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

3: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

4: _____ Relationship _____ Phone: (___) _____ - _____ initial [ ]

Completed by: _____ Date Completed:_____

I give my permission for medical treatment of the above-named child/children. I also give permission for the initialed authorized individual(s) above to make decisions regarding treatment, prescriptions and immunizations if I am not available to give my consent. I understand that I am financially responsible for non-covered charges. I hereby assign my insurance benefits to be paid directly to the physician and to release any information necessary to process my claim. In the event my account must be placed in collections, I agree to pay collection fee of 30% of account balance. **I have received Gilbert Pediatrics' Privacy Policy, and Financial Policy.**

SIGNATURE_____DATE_____