Please print clearly so that we can process your information quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (*First, M.I., Last)*_____ Date of Birth _____

Phone Number _____ Social Security # _____ Sex _____

Address _____ City/State _____ Zip _____

Ethnicity Hispanic/Non-Hispanic Race White/Asian/African American/American Indian/Pacific Islander/Other

PARENT/GUARDIAN INFORMATION

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number _____ Social Security # _____

Address _____ City/State _____ Zip _____

Employer _____ Phone Number _____

Employer Address_____

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number _____ Social Security # _____

Address _____ City/State _____ Zip _____

Employer _____ Phone Number _____

Employer Address_____

Who is guarantor (person financially responsible)? _____

EMERGENCY CONTACT (not a parent or guardian)

Name_____ Relationship to Patient _____

Address _____ City/State _____ Zip _____

Phone Number _____

I attest that all information is true and accurate.

_____ _____

Signature of Legal Guardian Date

INSURANCE INFORMATION

Insurance Company _____ Phone Number _____

Claims Address_____

Group # _____ Subscriber ID # _____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Social Security # _____ Date of Birth _____

Subscriber's Address (if different than guarantor) _____

Subscriber's Employer _____ Phone Number _____

Employer Address_____

I hereby authorize Gold Pediatrics, P.A. to furnish information concerning my/child's medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my/child's behalf by any and all insurance companies that cover the expenses incurred as the result of any diagnostic cervices or treatment provided by Gold Pediatrics, P.A.. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked by me in writing.

Signature of Legal Guardian _____ Date _____

CONSENT TO TREATMENT OF A MINOR

I hereby give my permission for Gold Pediatrics, P.A. and its physicians, nurse practitioners, and other associates to examine and treat my child whose name is listed below:

Patient's Name _____ Date of Birth _____

In addition, in the event that I cannot be contacted or am unable to attend the appointment, I hereby give my permission to the following individuals or institutions to consent to medical treatment of the above named child:

Name of Individual _____ Phone Number _____

Name of Institution _____ Phone Number _____

Parent or Guardian Name _____ Relationship to Patient _____

Parent or Guardian Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number _____

I acknowledge that Gold Pediatrics provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Parent/Guardian Signature **Date**