

WESTERVILLE PEDIATRIC SPECIALISTS, INC. /SUNBURY MILLS PEDIATRICS

Parent/Guardian Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Relationship: \_\_\_\_\_

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Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

PHARMACY Name, Address & Phone Number: \_\_\_\_\_

I give permission for my medical provider to access pharmacy information from the pharmaceutical clearing house: Yes No

CHILDREN:

Please circle:

Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In order to assist us in meeting Meaningful Use Measures with the U.S. Government, please answer the following questions below regarding your children:

Race: (Please circle one) American Indian or Alaskan Asian Black or African American Native Hawaiian or Other Refuse to Report/Unreportable White

Ethnicity: (Please circle one) Hispanic or Latino NonHispanic or Latino Refuse to Report

Primary Language: (Please circle one) English Hearing Impaired Other \_\_\_\_\_

INSURANCE INFORMATION (Please present insurance card upon check-in)

1) Name of Insurance Company: \_\_\_\_\_

Name of person who carries the insurance: : \_\_\_\_\_ SSN#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

2) Name of Insurance Company: \_\_\_\_\_

Name of person who carries the insurance: : \_\_\_\_\_ SSN#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Assignment and Release

Payment and/or copayment is required at the time the service is rendered. I hereby authorize my insurance benefits be paid directly to the physician, and I authorize the physician to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services. By my signature, I authorize release of immunization records, daycare forms, and medical records to another healthcare provider or daycare/school.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_