Facey Medical Group

With Providence

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 ☐ Hispanic/Latin/Spanish Origin
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ 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 Group and Providence 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:** ____/____/_____