LIGHTHOUSE PEDIATRICS

Patient Information Form

Children's Names	Nickname	Birthdate	Sex	Address same as below	If different, please specify
1.			M F	Y / N	
2.			M F	Y / N	
3.			M F	Y / N	
4.			M F	Y / N	
5.			M F	Y / N	

MOTHER	FATHER
Name: ________________	Name: ________________
DOB:________________	DOB:________________
Address: ________________	Address: ________________
City:________________ ZIP________	City/Zip:________________
Preferred Phone: ________________	Preferred Phone: ________________
Alternative Phone: ________________	Alternative Phone: ________________
Email: ________________	Email: ________________
Employer: ________________	Employer: ________________
Employer Phone#: ________________	Employer Phone#: ________________

Provider: (Circle one)   Dr. Dudley   Dr. Shepard

Ethnicity (circle): Hispanic   Not Hispanic   Declined

Race (circle): White   Black   Asian   Other________   Declined

Preferred Language for reminders: (circle one)   English   Spanish   Creole

Preferred contact # for appointment reminders ________________________ TEXT or CALL (Circle one)

Emergency Contact: (other than parents)

________________   ________________   ________________
Name   Relationship to Patients   Contact Number

PATIENT PORTAL:

We welcome you to our patient portal **"MY KID'S CHART",** where you can securely communicate with doctors and staff, view and print your child's medical record? We will e-mail the link where you can set it up.

Please provide preferred e-mail: ________________________________

Preferred Pharmacy: ________________ **Pharmacy Phone:**________________

Updated 02/19/19

INSURANCE INFORMATION

Primary Insurance Plan: ____

Policy holder's Name: ____ Date of Birth: _______/________/___________

Policy holder's employer:____

Primary Insurance Policy:#____Group# ______________________________

Insurance Address____Phone#:_________________________________

Is there a Secondary Insurance? If yes, Plan & Policy #:____

HIPAA ACKNOWLEGEMENT:

I acknowledge that I have received this office's Notice of Privacy practices which describes the ways in which the office may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the privacy officer designated on the notice if I have a question or complaint. To the extent permitted by law. I consent to the use and disclosure of my information for the purposes described in the office's Notice of Privacy Practices.

Signature____ Date:____________________________________

Patient, Parent or Guardian

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used to any of the following purposes: Diagnostic, insurance, legal, and at times when the doctor deems in necessary in order to ensure the best medical care on my behalf.

I further understand that any persons(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I authorize the release of any medical information necessary to process and claim. I permit a copy of the authorization to be used in place of original. This authorization may be revoked by either me or my insurance at any time in writing.

Your physician has remote access to the electronic medical record of the NCH Healthcare System and can view any testing or treatments provided to you at an NCH facility. Your permission is required to allow your physician remote access to your medical records.

Signature ____ Date ___________________________

Patient, Parent, or Guardian

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other patient information.

I have read the above and accept financial responsibility in full for this account.

Signature ____ Date ___________________________

Patient, Parent, or Guardian