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**	

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

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#: _____

Ethnicity (circle one) Hispanic Not Hispanic Declined

Race (circle one) 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

Updated 07/17/17

PATIENT PORTAL

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

Please provide e-mail:_____

Preferred
Pharmacy Name: _____ **Pharmacy Phone**_____

INSURANCE INFORMATION

Primary Insurance Policy Name: _____

Policy holder's Name: _____ Date of Birth: _____/_____/_____

Policy holder's employer:_____

Insurance holder's address: (if different fromabove)_____

Primary Insurance Policy:#_____Group# _____

Insurance Address_____Phone#:_____

Any Secondary Insurance? If yes, Plan & Policy #:_____

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.

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