

# LIGHTHOUSE PEDIATRICS

## Patient Information Form

Children's Names	Nickname	Birthdate	Sex	Child lives with
				Mom Dad Both other (specify)
1.			M F	
2.			M F	
3.			M F	
4.			M F	
5.			M F	

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

PARENT/GUARDIAN	PARENT/GUARDIAN
Relationship to patients (circle) Mother Father Other_____	Relationship to patients (circle) Mother Father Other_____
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#: _____

Who should receive the billing statements: \_\_\_\_\_

Race (circle): White Black Asian Other\_\_\_\_\_ Declined

Ethnicity (circle): Hispanic Not Hispanic Declined

Preferred Language: (circle one) English Spanish Creole

Preferred contact # for text reminders \_\_\_\_\_

Emergency Contact: (other than parents)

_____	_____	_____
<b>Name</b>	<b>Relationship to Patient</b>	<b>Contact Number</b>

### 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/text the link where you can set it up.

Please provide preferred e-mail or phone number: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

**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 ACKNOWLEDGEMENT:**

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.

**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/UPDATED OFFICE POLICIES AND PROCEDURES:**

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. I have read and understand the office policies and procedures that were given to me with this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient, Parent, or Guardian

Print Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_