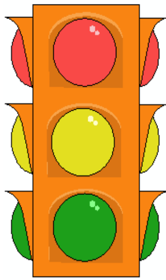

THE PEDIATRIC CLINIC

940 Holly N.E. Orangeburg, SC
Fax: 803-534-3118

WELCOME TO OUR PRACTICE!

PATIENTS THAT SHARE IDENTICAL INSURANCE INFORMATION

1) ______________________________ ____________ ________ ________________ ____________
LAST FIRST M.I. PREFERRED DOB Social Security Cell Phone

Race: Am. Indian/Alaskan Native * Asian * Black/AA * Nat. Hawaiian/Pacific Is. * Other * Unknown * White

Gender: M F **Ethnicity**: Hispanic * Non-Hispanic * Decline **Preferred Language**: English * Spanish

2) ______________________________ ____________ ________ ________________ ____________
LAST FIRST M.I. PREFERRED DOB Social Security Cell Phone

Race: Am. Indian/Alaskan Native * Asian * Black/AA * Nat. Hawaiian/Pacific Is. * Other * Unknown * White

Gender: M F **Ethnicity**: Hispanic * Non-Hispanic * Decline **Preferred Language**: English * Spanish

3) ______________________________ ____________ ________ ________________ ____________
LAST FIRST M.I. PREFERRED DOB Social Security Cell Phone

Race: Am. Indian/Alaskan Native * Asian * Black/AA * Nat. Hawaiian/Pacific Is. * Other * Unknown * White

Gender: M F **Ethnicity**: Hispanic * Non-Hispanic * Decline **Preferred Language**: English * Spanish

4) ______________________________ ____________ ________ ________________ ____________
LAST FIRST M.I. PREFERRED DOB Social Security Cell Phone

Race: Am. Indian/Alaskan Native * Asian * Black/AA * Nat. Hawaiian/Pacific Is. * Other * Unknown * White

Gender: M F **Ethnicity**: Hispanic * Non-Hispanic * Decline **Preferred Language**: English * Spanish

NEW ➡AUTHORIZATION TO TREAT/DISCUSS TREATMENT, RESULTS, AND PROCEDURES

It is important for us to know to whom (grandparents, step-parent, etc.) you allow to bring your child (children) to our office for treatment, to obtain results, and to be given instructions.

I, ________________________________, authorize the following people to consent to evaluation, treatment, and to be contacted if needed in case of an emergency of the above named patients.

NAME: ________________________ RELATIONSHIP to PT: _________________ PHONE #: ______________

NAME: ________________________ RELATIONSHIP to PT: _________________ PHONE #: ______________

NAME: ________________________ RELATIONSHIP to PT: _________________ PHONE #: ______________

Complete both sides →

PARENT OR GUARDIAN

☐ Check here IF this is the name that is listed on insurance card

Correct and current information is essential. Notify our office when any changes occur.

Name: ____________________ Relationship: ____________________ DOB: ________

SS#: ____________________ Home Phone: ______________ Cell Phone: ___________

Work Phone: ________________ **Preferred Contact #:** Home Cell Work Other: __________

Mailing Address: ____

STREET CITY STATE ZIP

E-mail Address: ________________________ Employer: ___________________________

OTHER PARENT OR GUARDIAN

☐ Check here IF this is the name that is listed on insurance card

Correct and current information is essential. Notify our office when any changes occur.

Name: ____________________ Relationship: ____________________ DOB: ________

SS#: ____________________ Home Phone: ______________ Cell Phone: ___________

Work Phone: ________________ **Preferred Contact #:** Home Cell Work Other: __________

Mailing Address: ____

STREET CITY STATE ZIP

E-mail Address: ________________________ Employer: ___________________________

PARENT'S RELATIONSHIP: MARRIED * Never MARRIED * DIVORCED * OTHER: ______________

Are there any custodial concerns/issues that impact authorization of medical care? YES NO

If yes, please explain:____

____

____

We may need to disclose health information about your child (children) to other physicians, nurses, technicians, office staff, or other personnel involved in the treatment of your child (children). I hereby authorize the office to furnish minimal necessary information to my insurance carrier concerning my child's (children's) illness and hereby assign The Pediatric Clinic all payment for medical services rendered. I further understand that I am financially responsible for charges at the time of service unless prior arrangements have been made.

Person completing this form
I hereby certify under penalty of perjury that I am an adult who is legally authorized to make medical decisions about this minor patient .

DATE: ________ RESPONSIBLE PARTY SIGNATURE: ______________________________