Date ________ **HENDERSONVILLE PEDIATRICS, P.A.** Chart # ___________

18 Years & Older

Please Use Gel Pen or Other Dark (Black) Pen to Complete

PATIENT INFORMATION

Last Name ____________________ First Name ____________________ Middle Initial ______ Sex ____

Date of Birth _____/_____/___________ Age: _________ Years ________ Months

Race ____________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language ____________________

Primary Phone ______________________________ Preferred Physician: ____________________________________

Primary Address _______________________ Apt # ______ City ____________________ State _____ Zip ______

Who does the child live with ____________________ Relationship to Patient ___________ Phone ________________

Emergency Contact other than a parent/guardian ____

FAMILY RESPONSIBLE PARTY INFORMATION

☐ Check here if patient is now responsible for all insurance coverage and payments.
If not, please complete the following information.

Parent/Guardian

Name ____

Mailing Address ______________________________

City ____________________ State _____ Zip _______

Relationship to Patient _________ Legal Custody (Y/N)

Date of Birth ____/____/______ SSN # _____/____/______

Email ______________________________________

Parent/Guardian

Name ____

Mailing Address ______________________________

City ____________________ State _____ Zip _______

Relationship to Patient _________ Legal Custody (Y/N)

Date of Birth ____/____/_______ SSN # _____/____/______

Email ______________________________________

AUTHORIZED INDIVIDUALS

Please list all persons (parents, grandparents, siblings, etc.) that are allowed to receive the specified information below.

Name ______________________________ Relationship ___________ Phone _______________ ☐ Medical ☐ Billing ☐ Demographic

Name ______________________________ Relationship ___________ Phone _______________ ☐ Medical ☐ Billing ☐ Demographic

Name ______________________________ Relationship ___________ Phone _______________ ☐ Medical ☐ Billing ☐ Demographic

INSURANCE INFORMATION

Policy Name ____________________________________ Policy Holder ____________________________________

Employer ______________________________________ Policy Number ___________________________________

(See Back)

Patient Name:____ **Chart #:**____________________

Authorization to Consent to Health Care for Minor

By signing this statement, I authorize the doctors and staff of Hendersonville Pediatrics, P.A. to provide necessary health services for my child, even if I am not present. Furthermore, the name, relationship to patient, and phone number of all people who may schedule appointments, call for medical advice or bring your child to the office for treatment will be provided to this office. If someone other than these persons contacts us relative to your child, or in the event of a medical emergency, we will attempt to contact the parent or guardian for permission to treat. I authorize Hendersonville Pediatrics, P.A. to release my child's medical records to any party involved in their treatment.

Parent or Legal Guardian Signature Print Name

Financial Policy

I hereby authorize Hendersonville Pediatrics, to furnish medical information to insurance carriers concerning my child/children's illness and treatment. Please present your current insurance ID card at every visit and if anything changes you agree to contact us immediately. Our office makes every reasonable effort to obtain payment according to your coverage. If your insurance company rejects the claim or denies payment our office will bill you for the unpaid portion. All co-payments are to be paid at time of service. I authorize payment of all applicable benefits directly to Hendersonville Pediatrics. This authorization will remain in effect until revoked by me in writing.

Parent or Legal Guardian Signature

Code of Conduct Policy

Patient and Staff Safety: Our office is committed to the safety of our patients, their families, and our staff. Any verbal abuse, threatening, aggressive, and destructive behavior will not be tolerated. Firearms, including concealed firearms are not permitted within any of our office locations. While we understand that disagreements may occasionally occur, these need to be resolved in a civil manner. Depending on the degree of infraction, we reserve the right to involve Child Protective Services, law enforcement, and other appropriate agencies should we deem it necessary. We may press charges at our discretion.

Parent or Legal Guardian Signature

Missed Appointment Policy

I acknowledge families missing a total of four appointments without calling or prior notification will result in termination of care from the practice.

Parent or Legal Guardian Signature