

Date \_\_\_\_\_ **HENDERSONVILLE PEDIATRICS, P.A.** Chart # \_\_\_\_\_

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: \_\_\_\_\_

Emergency Contact other than a parent/guardian \_\_\_\_\_

Primary Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who does the child live with \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

**FAMILY INFORMATION**

**Parent/Guardian**

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Legal Custody (Y/N) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN # \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

**Parent/Guardian**

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Legal Custody (Y/N) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN # \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

**PLEASE LIST ALL CHILDREN UNDER 18 YEARS OLD**

1. Childs Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Biological (Y/N) \_\_\_\_\_

2. Childs Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Biological (Y/N) \_\_\_\_\_

3. Childs Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Biological (Y/N) \_\_\_\_\_

4. Childs Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Biological (Y/N) \_\_\_\_\_

5. Childs Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Biological (Y/N) \_\_\_\_\_

**AUTHORIZED INDIVIDUALS**

Please list all people, other than parent guardian, who may schedule appointments, and what type of information each person is allowed to receive. (i.e. grandparents, baby-sitter, neighbor).

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  Medical

Billing  
 Demographic

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  Medical

Billing  
 Demographic

**INSURANCE INFORMATION**

Policy Name \_\_\_\_\_ Policy Holder \_\_\_\_\_

Employer \_\_\_\_\_ Policy Number \_\_\_\_\_

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.

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Parent, or Legal Guardian Signature

**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.

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Parent, or Legal Guardian Signature

**Code of Conduct Policy**

Appointment Cancellations / No-shows: You agree to call in advance to cancel your child's appointment if they are unable to attend. Repeated cancellations, rescheduled appointment, or no-shows are disruptive to your child and other patient's care and should be avoided.

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.

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Parent, or Legal Guardian Signature

Print Name