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 _____/_____/_____ Preferred Physician _____

Race _____ Ethnicity ☐ Hispanic ☐ Non-Hispanic Preferred Language _____

FAMILY INFORMATION

Parent/Guardian (circle one)

Name_____

Mailing Address _____

City _____ State _____ Zip _____

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

Relationship to Patient _____ (Bio/Step/Other)

Custody ☐ Joint ☐ Exclusive Marital Status _____

Home Phone_____ Cell _____

Email_____

Preferred contact method? ☐ Phone ☐ Text ☐ Email

Employer _____Work Ph._____

☐ By checking this box, I agree that information for my child can be left on voicemail.

Parent/Guardian (circle one)

Name_____

Mailing Address _____

City _____ State _____ Zip _____

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

Relationship to Patient _____ (Bio/Step/Other)

Custody ☐ Joint ☐ Exclusive Marital Status _____

Home Phone_____ Cell _____

Email_____

Prreferred contact method? ☐ Phone ☐ Text ☐ Email

Employer _____Work Ph._____

☐ By checking this box, I agree that information for my child can be left on voicemail.

PLEASE LIST ALL CHILDREN UNDER 18 YEARS OLD

1. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)
2. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)
3. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)
4. Childs Full Name _____ Date of Birth _____ Bio Sib? (Y/N)
5. Childs Full Name _____ Date of Birth _____ Bio Sib? (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 ☐ Appointment

Name_____ Relationship _____ Phone _____ ☐ Medical ☐ Billing ☐ Appointment

INSURANCE INFORMATION

Policy Name _____ Policy Holder _____

Employer _____ Group 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

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

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.

_____

Parent or Legal Guardian Signature Print Name