PATIENT INFORMATION FORM

Account #: _____

Please list all children in the family.

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Home Address: _____
Street City State Zip

PRIMARY: (_____)_____-_____ Secondary: (_____)_____-_____ Email: _____

EMERGENCY CONTACT: _____ Phone: (_____)_____-_____
Name

I authorize Beach Pediatrics to leave messages or send text messages at the primary number listed above regarding my child's health information, appointments, test results, and billing unless otherwise specified. ☐ Yes ☐ No

I authorize Beach Pediatrics to email me at the email address listed above regarding my child's health information, appointments, and test results unless otherwise specified. ☐ Yes ☐ No

Please select all that apply *(optional)*: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ Asian

Please circle one. **Mother / Father / Guardian**

Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Cell: (_____)_____-_____ Work: (_____)_____-_____

Occupation: _____ Employer: _____

Please circle one. **Mother / Father / Guardian**

Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Cell: (_____)_____-_____ Work: (_____)_____-_____

Occupation: _____ Employer: _____

Parents of the child/children are: ☐ Single ☐ Married ☐ Divorced ☐ Separated

If the parents are divorced or separated, what are the legal custody arrangements for the child/children? ☐ Sole ☐ Joint

If sole legal custody, please provide legal documentation to be scanned into patient(s)'s chart.

CAREGIVER AUTHORIZATION — I, the parent/guardian, give authorization to the following relatives and/or caregivers to bring my child/children in for sick visits, testing and/or treatment which is recommended and provided by the physicians and staff of Beach Pediatrics. **This Authorization will remain in effect until further written notice.**

Name/Relationship:_____ Name/Relationship:_____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Name of Subscriber: _____

ID#: _____

Group #:_____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____

Name of Subscriber: _____

ID#: _____

Group #:_____

PHARMACY

Name: _____ Location/Zip:_____ Phone: (_____) _____-_____

I declare the information I provided above is correct, and if there are any changes, I will notify Beach Pediatrics.

Parent/Guardian Signature: _____ Date: _____/_____/_____