Palatine Pediatrics

Patient Information

First Name:_____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

Please list siblings oldest to youngest:

First Name:_____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

First Name:_____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

First Name:_____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

First Name:_____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

ADDRESS: _____ Apt: _____

City: _____ State:_____ Zip Code: _____

***CHILD LIVES WITH*:** ☐ Both Parents **(Together)** ☐ Both Parents **(Separately/Joint custody)** (*Who is primary?* _____)

☐ Mother Only ☐ Father Only ☐ Other _____

***CHILD'S ETHNICITY*:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to answer

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CHILD'S RACE(S) (PLEASE MARK ALL THAT APPLY): ☐ African American / Black ☐ American Indian / Alaska Native ☐ Asian

☐ Caucasian / White ☐ Pacific Islander ☐ Decline to answer

CHILD'S PRIMARY LANGUAGE(S): 1._____ 2._____

FATHER ☐ Birth Parent ☐ Adoptive Parent ☐ Step Parent

Nickname:_____

Legal First Name:_____

Last Name: _____

Date of Birth: _____ SSN:_____

Employer: _____

Occupation:_____

Home Phone:_____

Cell Phone: _____

Work Phone: _____

E-Mail:_____

MOTHER ☐ Birth Parent ☐ Adoptive Parent ☐ Step Parent

Nickname:_____

Legal First Name:_____

Last Name: _____

Date of Birth: _____ SSN:_____

Employer: _____

Occupation:_____

Home Phone:_____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Assignment and Release: I hereby authorize insurance benefits to be paid directly to the physician. I attest that the above information is complete and accurate.

Printed Name of Parent/Legal Guardian:_____ Date: _____

Parent/Legal Guardian's Signature: _____

How did you hear about us? ☐ Insurance ☐ Office website ☐ Hospital ☐ Friends/Family_____

☐ Internet ☐ Advertisement ☐ Other _____

Palatine Pediatrics

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I hereby give my consent to Palatine Pediatrics to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my children's records (list all):

Name of Child: _____ Date of Birth: _____

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Name of Child: _____ Date of Birth: _____

Name of Child: _____ Date of Birth: _____

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose their confidential information.

I understand that the physician has reserved his/her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me when available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where my physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Fax Waiver

I understand that Palatine Pediatrics, under the direction of the physician, may need to transmit medical information for my children via fax. I understand that Palatine Pediatrics takes every measure possible to ensure that the transmission is received by the intended individual. However, if someone may receive the transmission in error, I will not hold Palatine Pediatrics or the physician liable. I have been informed that all of the transmissions are sent with a fax cover page that does have a confidentiality statement.

Parent/Legal Guardian's Name: _____ Date:_____

Parent/Legal Guardian's Signature:_____