

Please PRINT & please list all children in order of oldest to youngest

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

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

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ADDRESS: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

CHILDREN LIVE WITH: Both Parents (**Together**) Both Parents (**Separately/Joint custody**) (*Who is primary?* _____)
 Mother Only Father Only Other _____

CHILDREN'S ETHNICITY: Hispanic/Latino Not Hispanic/Latino Decline to answer

CHILDREN'S RACE(S) (PLEASE MARK ALL THAT APPLY): African American / Black Alaska Native or Native American Asian
 Caucasian / White Pacific Islander Decline to answer

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

FATHER Birth Parent Adoptive Parent Step Parent
 Foster Parent Other _____

MOTHER Birth Parent Adoptive Parent Step Parent
 Foster Parent Other _____

Nickname: _____

Nickname: _____

Legal First Name: _____

Legal First Name: _____

Last Name: _____

Last Name: _____

Date of Birth: _____ SSN: _____

Date of Birth: _____ SSN: _____

Employer: _____

Employer: _____

Occupation: _____

Occupation: _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Work Phone: _____

Work Phone: _____

E-Mail:* _____

E-Mail:* _____

*E-mail is for portal use only. We do not communicate via 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? Facebook Google Office Website Friends/Family _____
 Internet Insurance Hospital Advertisement Other _____



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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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: _____