



# Contact Information

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  Boy  Adopted

Date of Birth: \_\_\_\_\_  Girl  Foster Care

Home Address: Street \_\_\_\_\_

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

Home Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Work Ph#: \_\_\_\_\_ Email: \_\_\_\_\_

Insurance:  Blue Cross  United  Cigna  Aetna

Amerigroup  WellCare

Other \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

This child's insurance coverage will be under whose plan?  Mother  Father

Who is financially responsible for amounts not paid by the above insurance plan ?

Responsible Party's Name: \_\_\_\_\_

Responsible Party's Soc. Sec. #: \_\_\_\_\_

Responsible Party's Date of Birth: \_\_\_\_\_

If the Responsible Party's address is different than the patients, complete the following:

Responsible Party's Address: \_\_\_\_\_

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

Home Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Work Ph#: \_\_\_\_\_ Email: \_\_\_\_\_

## Privacy and Consent Agreements

Please review our Privacy and Consent Agreements listed below:

- Billing and Finances
- Informed Consent for Care
- Privacy/Confidentiality of Health Information
- Electronic Medical Records
- E-Mail Communication

By signature below I declare that I have read, understand and consent to abide by all the terms of the agreements as listed.

Parent Name (print) \_\_\_\_\_

Signature (parent/legal guardian): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_