PATIENT'S NAME ______________________________ **BIRTHDATE** ____________

__ Male __ Female Insurance Company ______________________________ ID# ____________

STREET ADDRESS ____

CITY __________________________________ STATE ____________ ZIP ________________

PRIMARY PHONE (____) ___________ Cell __ or Home __

MOM CELL PHONE (____) ________________ DAD CELL PHONE (____) ________________

EMAIL: ____

MOTHER'S NAME ________________________ **DOB** ____________ **SS#** ________________

ADDRESS (if different than above) ____

MOTHER'S EMPLOYER ____________________________ OCCUPATION ________________

EMPLOYER'S ADDRESS & PHONE ____

FATHER'S NAME ________________________ **DOB** ____________ **SS#** ________________

ADDRESS (if different than above) ____

FATHER'S EMPLOYER ____________________________ OCCUPATION ________________

EMPLOYER'S ADDRESS & PHONE ____

FOSTER PARENT / GUARDIAN NAME ______________________________ **DOB** __________

HOME ADDRESS ____________________________________ PHONE ________________

EMPLOYER'S NAME / PHONE ____ ____________

I have read, understand, and authorize the disclosures / consents on the back of this form.

Parent / Guardian Name (please print) ____

Parent / Guardian Signature ____

Relationship to Patient(s) ___________________________________ **Date** ________________

Please list children with the same information on the back of this form.

Patient's Name ______________________ **Date of Birth** ____________

__ Male __ Female Insurance Company ______________________ ID# ________

Patient's Name ______________________ **Date of Birth** ____________

__ Male __ Female Insurance Company ______________________ ID# ________

Patient's Name ______________________ **Date of Birth** ____________

__ Male __ Female Insurance Company ______________________ ID# ________

Patient's Name ______________________ **Date of Birth** ____________

__ Male __ Female Insurance Company ______________________ ID# ________

Patient's Name ______________________ **Date of Birth** ____________

__ Male __ Female Insurance Company ______________________ ID# ________

Disclosures & Consents

I understand that it is my responsibility to provide Pediatric & Adolescent Medical Associates (PAMA) with my child's most up-to-date contact information and insurance information.

Consent for Care: I hereby give my permission to the professional staff at PAMA to examine, provide treatment, refer, obtain records and/or perform any tests deemed necessary for the care of my child.

Assignment of Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to PAMA.
I understand that it is my responsibility to know my insurance benefits, and whether or not the services rendered are a covered benefit. I acknowledge that I am financially responsible for any copays at the time of service or unpaid balance after my insurance claim has settled. I also authorize PAMA to release any information required by my insurance company.

I authorize PAMA to mail or call me with communications regarding my child's healthcare, including, but not limited to such things as appointment reminders, referral arrangements, and laboratory results.
This authorization extends to my home answering machine and/or cell phone voice mail.

Notice of Privacy: I certify that I have received a copy of PAMA's Summary of Privacy Practices.
I understand that I may receive a copy of PAMA's Complete Notice of Privacy Practices upon request.

I understand that I may revoke my authorization at any time by notifying PAMA in writing.
The revocation will only be effective from the date it is received by PAMA, and will not apply retroactively.

We strive for a mutually trusting relationship with our patients and their families. Noncompliance with medical appointments or medical recommendations, rude or disruptive behavior, or nonpayment of bills may lead to discontinuation from our practice.