Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A.

Patient/Child Information

Last Name_____ Home Phone #_____

First Name_____ Middle Initial_____ **Patient** Mobile Phone #_____

Address_____ **Patient** Email _____

City_____ Zip Code_____ Preferred Provider/Physician_____

DOB_____ Gender (Circle) Male Female Primary Ins. Co. Name_____

Patient's Mothers Maiden Name_____ Language_____ Race_____

Ethnicity (*Please Circle*)

Hispanic/Latino Non-Hispanic/Latino Declined

Siblings at this Address: _____ _____ _____

Name/DOB Name/DOB Name/DOB

Father's Information

Last Name_____ First Name_____ M___

☐ *Address same as patient*

Address_____

City_____

Zip Code_____ DOB_____

Home Phone #_____

Mobile #_____Work #_____

Employer Name_____

Email_____

Mother's Information

Last Name_____ First Name_____ M___

☐ *Address same as patient*

Address_____

City _____

Zip Code_____ DOB_____

Home Phone #_____

Mobile # _____Work#_____

Employer Name_____

Email_____

CONSENT OF **PARENTS/GUARDIANS OF MINOR PATIENTS**

TO DISCLOSE HEALTH INFORMATION FOR PAYMENT,
TREATMENT AND HEALTH CARE OPERATIONS

By my signature below, I hereby authorize the Jeffers Mann and Artman Pediatric and Adolescent Medicine, P.A. to disclose my child's medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child, seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment, seek treatment, obtain prescription(s) or other medical forms: (please list only people over the age of 18 and their relationship to the patient. For example: (Tom Jones, grandfather)

☐ **None**

Name: _____ Phone: _____Relationship to Patient: _____

Name: _____ Phone: _____Relationship to Patient: _____

ASSIGNMENT OF INSURANCE BENEFITS

By my signature below, I authorize medical benefits to be paid to Jeffers Mann and Artman Pediatrics and Adolescent Medicine, P. A. on my behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates.

_____ _____ _____

Signature of parent/guardian/personal representative of minor child **Relationship to patient** **Date**

*Office Use Only*_____ _____

Initial *Date*