Acct # _____ **Children's Clinic East** Date _____

Patient's Last Name	**First Name / Middle Initial**	**Patient's Social Security #**
Patient's Date of Birth	**Patient's Sex (circle) Male Female**	**Primary Language**

Street Address	**City, State, Zip**
E-mail Address	**Preferred Provider**
Emergency Contact Name (other than parents)	**Emergency Contact Phone #**

Patient's Race

□ American Indian/Alaska Native
□ Asian
□ Black/African American
□ Declined
□ Native Hawaiian/Pacific Islander
□ Other Race
□ White / Caucasian

Patient's Ethnicity

□ Declined
□ Hispanic or Latino
□ Not Hispanic or Latino

Best way to contact you for appts:

□ Home phone / message
□ Mom's cell
□ Dad's cell
□ Text message at _____
□ E-mail to address above
□ Other _____

Patient's Mother's Name	**Mom's Birth Date**	**Home Phone**	**Mom's Cell Phone**
Patient's Father's Name	**Dad's Birth Date**	**Home Phone**	**Dad's Cell Phone**
Mother's Social Security #		**Father's Social Security #**	
Sibling's Name		**Sibling's date of birth**	
Sibling's Name		**Sibling's date of birth**	

Primary Insurance Company Name	**Policy Holder's Name**	
Policy Holder's Employer	**Policy Holder's Date of Birth**	**Policy Holder's Social Security #**
Secondary Insurance Company Name	**Policy Holder's Name**	
Policy Holder's Employer	**Policy Holder's Date of Birth**	**Policy Holder's Social Security #**

I confirm that this information is accurate and will become part of my child's medical record.

_____ _____

Signature **Date**

Communication is more convenient than ever through our secure patient portal.
Just log on to www.ChildrensClinicEast.com to set up an account.

Account # _____ Date _____

Children's Clinic East

Releases and Authorizations

Patient's Name_____

Patient's date of birth _____

I hereby assign medical benefits due to me be paid directly to Children's Clinic East, P.C. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor or medical provider for the continuation of my child's medical care. I understand that a photocopy of this release is as valid as the original.

×_____ ×_____

Signature of Parent or Legal Guardian Date

I understand that I am fully responsible for payment in full for any services rendered by Children's Clinic East not covered by insurance benefits. In the event this account is turned over to collections, to protect the interests of Children's Clinic East, I understand that I will also incur the cost of said collection, which could include reasonable attorney fees and court costs.

×_____ ×_____

Signature of Parent or Legal Guardian Date

I hereby give permission to the physicians, physician assistants, and nurse practitioners of Children's Clinic East to perform emergency/urgent surgical, medical, or diagnostic procedures necessary to treat my child for his/her condition. This permission is primarily for use in emergent/urgent situations.

I understand that I, a custodial adult, or another responsible and knowledgeable adult must accompany my child for all clinic visits. If permission is needed for other responsible adults to accompany my child to a visit, I must provide written permission in advance by completing the form entitled Consent to Treatment of a Minor When Parents/Guardians are Temporarily Unavailable which is available upon request at any Children's Clinic East front desk.

×_____ ×_____

Signature of Parent or Legal Guardian Date

×_____

My relationship to patient

Below to be completed by Office Staff

_____ _____

Witness Date

Account # _____

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

I, the undersigned parent or legal guardian of _____ authorize the person(s) listed
(Child's Name)
below to consent to treatment of the child when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present. This permission also allows the below named adults to be present in the exam room to hear protected patient information and to make medical decisions during the visit.

1. Person(s) who may consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____
3. Known allergies: _____

Name of Parent or Legal Guardian: _____Relationship to Child:_____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Signature: _____ Date: _____

This Consent is effective until withdrawn in writing by the child's parent or guardian.

☐ Copy of driver's license of legal guardian copied and scanned into patient's record with this consent form.