Thomasville Pediatrics
Archdale – Trinity Pediatrics

PATIENT INFORMATION

PLEASE FILL OUT EACH LINE ON THE ENTIRE FORM

PATIENT NAME_____ (Nickname: _____)

Address _____
STREET CITY STATE / ZIP

Date of Birth _____ Place of Birth _____ **BEST PHONE #** ( ) _____ - _____
☐ HOME ☐ WORK ☐ CELL

Social Security # _____ Sex: (check one) ☐ Male ☐ Female

PLEASE INDICATE THE FOLLOWING FOR THE CHILD:

Race:
- ☐ W = Caucasian
- ☐ B = African American
- ☐ A = Asian
- ☐ I = American Indian / Native Alaskan
- ☐ 1 = Black & White
- ☐ 2 = Asian & White
- ☐ 3 = Black and Asian
- ☐ U = Unknown / Refuse to answer

Ethnicity:
- ☐ H = Hispanic / Latino
- ☐ N = Non-Hispanic / Non = Latino
- ☐ U = Unknown / Refuse to answer

Preferred Language:
☐ English ☐ Spanish ☐ Other _____

FAMILY INFORMATION:

MOTHER / LEGAL GUARDIAN

Name: _____

Date of Birth: ____/____/____ SS# _____

Mailing Address: _____
STREET

_____
CITY STATE / ZIP

Home Phone (_____) _____ - _____

Work Phone (_____) _____ - _____

Cell Phone (_____) _____ - _____

Employer: _____

Email:

FATHER / LEGAL GUARDIAN

Name: _____

Date of Birth: ____/____/____ SS# _____

Mailing Address: _____
STREET

_____
CITY STATE / ZIP

Home Phone (_____) _____ - _____

Work Phone (_____) _____ - _____

Cell Phone (_____) _____ - _____

Employer:_____

Email:

Who is the person responsible for this account? ☐ BOTH ☐ FATHER ☐ MOTHER ☐ OTHER _____

INSURANCE INFORMATION: BE AWARE THAT YOU WILL BE ASKED FOR YOUR INSURANCE CARD AT **EVERY** VISIT

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT) :

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Signature: _____ Date: _____

REV. 4/2016

Thomasville Pediatrics
Archdale-Trinity Pediatrics

HIPAA & AUTHORIZATION

PLEASE FILL OUT ACCORDINLGY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION (PHI):

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIMARY INSURANCE:

Insurance Company: _____

Policy Number: _____

Group Number: _____

Employer: _____

Name of Policy Holder: _____

SECONDARY INSURANCE:

Insurance Company: _____

Policy Number: _____

Group Number: _____

Employer: _____

Name of Policy Holder: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician designated to release information acquired in the course of the examination and treatment.. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number. With my signature on this form, I authorize and consent to the release of my (or my child's) medical records to Thomasville Archdale-Trinity Pediatrics. I understand and agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

AUTHORIZATION FOR PAYMENT: I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I understand that I am financially responsible for charges not covered by my insurance, whether private or Medicaid, and I hereby guarantee timely payment in full for any such charges.

I have read the consent form and the Notice of Privacy Practices and I agree with the terms stated in the notice. Also, I agree that in order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier (Patient's Date of Birth): _____

Signature of Patient, Parent or Legal Guardian: _____ Date: _____