GI CARE FOR KIDS, L.L.C

PATIENT INFORMATION

Patient's Legal Name: _____ Nickname: _____

Date of Birth:___/___/___ Sex: Male Female Patient Social Security #: _____

Address: _____

City: _____ ST: _____ Zip Code: _____ Best Contact #: _____

Email: _____ **Preferred Pharmacy:** _____

Pharmacy Address: _____ Pharmacy Phone: _____

(Required Questions Per Government Meaningful Use) **Please CIRCLE ONE ON EACH QUESTION Below**

ETHNICITY: Hispanic or Latino / Non Hispanic or Latino / Patient Not Present / Unknown / Declined

RACE: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander White / Declined / Unknown / Patient Not Present

Preferred appointment confirmation method: (Please circle one) Text Email Phone

PARENTS' INFORMATION

Mother's Information	***Father's Information***
Name: _____ DOB: _____	Name: _____ DOB: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Ph #: _____ Cell #: _____	Home Ph #: _____ Cell #: _____
Employer: _____ Occupation: _____	Employer: _____ Occupation: _____
Work #: _____	Work #: _____

With whom does the child live? ☐ Mom & Dad together ☐ Mom ☐ Dad ☐ Other: _____

Who has Legal custody? ☐ Mom & Dad together ☐ Mom ☐ Dad ☐ Other: _____

EMERGENCY CONTACT

Emergency Contact: _____ Relation: _____ Phone # : _____

PEDIATRICIAN INFORMATION

Primary Care Physician (PCP): _____

Address: _____ Phone #: _____ Fax #: _____

If referred by another physician, Who? _____

INSURANCE INFORMATION

Is there a court order/divorce decree dictating who is responsible for primary health coverage? ☐ Yes ☐ No

If so, Who is listed?: _____

Primary Insurance Company: _____ Insurance Phone #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Effective Date: ___/___/___ ID #: _____ Group #: _____

Secondary Insurance Company: _____ Insurance Phone #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Effective Date: ___/___/___ ID #: _____ Group #: _____

AUTHORIZATION

- **I authorize that I brought in the patient and I am responsible for payment for services rendered to my dependant.**
- I authorize the release of medical information necessary to process my insurance claim for services rendered by CCDHC.
- I authorize payment of medical benefits to CCDHC for medical treatment rendered to my dependant.
- I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Signed: _____ Print: _____ Date: _____