PROVIDENCE PEDIATRIC PRACTICE,LLC
100 Granite Drive, Suite 200
Media, PA 19063-5134

ANNUAL UPDATE DEMOGRAPHIC INFORMATION AND CONSENT FORM

Father_____
DOB_____
Address
Street_____
City_____State_____ZIP_____
Phone Number Cell_____
Land_____
Work_____
Email address_____

Mother_____
DOB_____
Address
Street_____
City_____State_____ZIP_____
Phone Number Cell_____
Land_____
Work_____
Email Add_____

Preferred Number for Contact_____

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST AT EACH VISIT

Insurance_____
Employer_____

Insurance_____
Employer_____

If parents are separated or divorced, please enter name of custodial parent
_____

Please enter name of guarantor
_____

NOTE: Copay must be made at the time of service, regardless of who brings the child. A billing charge will be added if copay not made at time of service.

Child's Name_____
DOB_____Race_____
Is Child Hispanic or Latino: yes no
Child's Name_____
DOB_____Race_____
Is Child Hispanic or Latino: yes no

Child's Name_____
DOB_____Race_____
Is Child Hispanic or Latino: yes no
Child's Name_____
DOB_____Race_____
Is Child Hispanic or Latino: yes no

Negative test results may be left on my answering machine yes____ no____
Test Results may be given to family members_____yes____ no____
PLEASE BE ADVISED, THAT YOU ARE RESPONSIBLE FOR DETERMINING WHICH LABORATORY YOU ARE REQUIRED TO USE ACCORDING TO YOUR INSURANCE PLAN. FAILURE TO DO SO WILL RESULT IN PERSONAL CHARGES FOR LABORATORY SERVICES.
ALSO, THERE IS NO GUARANTEE THAT LABORATORY TESTS, EVEN WHEN ORDERED BY YOUR DOCTOR, WILL BE COVERED BY YOUR INSURANCE PLAN.
IT IS THE POLICY OF THIS OFFICE TO CALL PATIENTS WITH TEST RESULTS, WHETHER POSITIVE OR NEGATIVE. iF YOU DO NOT RECEIVE A CALL WITHIN ONE WEEK, PLEASE CALL THE OFFICE.

Please indicate any person/persons with whom we may discuss your children's Medical Records, Test Results and any medical information.
Name_____Relationship_____
Name_____Relationship_____
School Nurse _____yes _____no

I, _____(parent or guardian) do hereby authorize Providence Pediatric Practice to submit claims to my insurance company for payment for services rendered. I further authorize the release of any medical information necessary to adjudicate and process claims. I also authorize the release of, or obtaining of, medical and/or other coverage information to and from another organization with which my child/children has/have other medical benefits plans or health insurance coverage.
I understand that any services not covered by my health insurance will be my personal responsibility.
I give consent to Providence Pediatric Practice to review my child's/children's retail pharmacy medication history.
This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, AT YOUR REQUEST, to your health insurer or employer.
Signature_____Date_____
Relationship to Patient_____Date_____