Patient's Name_____ Male/Female Birth date_____
(First) (Middle Initial) (Last)
Address _____City/State_____ Zip_____
Child's SS # _____ Race (please circle) American Indian/Alaska Native, Asian, White, Native Hawaiian/Pacific Islander, African American, Hispanic, Other _____ Decline to answer

Mother's Name _____Maiden Name_____ Birth date_____ SS#_____
Address_____ City/State _____Zip_____
Home Phone _____ Cell Phone_____ Email _____
Employer _____Occupation _____ Work Phone _____

Father's Name _____Birth date _____ SS# _____
Address _____ City/State _____Zip _____
Home Phone _____ Cell Phone _____ Email _____
Employer _____ Occupation _____Work Phone _____

Emergency Contact (other than parent)
Name _____ Relationship _____Home Phone_____
Cell Phone _____

Siblings/Other children in household
Name _____ Birth date _____, Name _____ Birth date _____
Name _____ Birth date _____, Name _____ Birth date _____

Other Adults involved in child's care
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE HOLDER/RESPONSIBLE PARTY/GUARDIAN
Insurance Company _____
Subscriber Name _____Relationship _____ Birth date _____
SS# _____ Address _____ City/State _____Zip _____
Home Phone _____ Work Phone _____ Employer _____

SECONDARY INSURANCE HOLDER
Insurance Company _____
Subscriber Name _____Relationship _____ Birth date _____
SS# _____ Address_____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ Employer _____

I hereby consent for Alecia A. Hanes, M.D. Pediatrics to provide medical treatment for my child, named above, and further state that I am the natural parent/guardian of said minor child. I further understand that I am responsible for all charges, regardless of insurance coverage. The office may file my insurance as a courtesy to the patient and I hereby assign to the clinic all payments for medical services rendered to the above child.

I have received Alecia A. Hanes, M.D. Pediatrics Notice of Privacy Practices and have been provided an opportunity to review it. With my consent, this office may use and disclose my child's Protected Health Information to carry out Treatment, Payment, and Health Care Options.

Signature _____Date _____
Printed Name _____Relationship _____ (Revised 3/1/17)