Today's Date:_____/_____/_____
Referred By:_____

CHILD INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

GENDER	RACE	ETHNICITY
☐Male ☐Female	☐American Indian/Alaskan Native ☐ Asian ☐Black/ African American	☐Hispanic/Latin
Do You Vaccinate: ☐NO	☐Native Hawaiian/Pacific Islander ☐White ☐Refuse to Report	☐Non-Hispanic/Latin
☐**YES:** ☐All Recommended	☐Other_____	☐ Refuse to Report
☐Alternative Schedule		

Mailing Address	City	State	Zip
Physical Address(if different from mailing)	City	State	Zip
Home Phone ☐Preferred	Alternate Phone ☐Preferred	**Name of Daycare/School**	

PARENT/LEGAL GUARDIAN #1

LAST NAME	FIRST NAME	RELATIONSHIP TO CHILD (Check all that apply) ☐Mother ☐Father ☐Legal Guardian ☐Other

Address: ☐Check if same a patient	City	State	Zip
Home Phone ☐Preferred	Cell Phone ☐Preferred	Work Phone ☐Preferred	
Email	Social Security #:	Date of birth (mm/dd/yyyy)	

GENDER	Employer Name	Employer Phone
☐Male ☐Female ☐Other		

PARENT/LEGAL GUARDIAN #2

LAST NAME	FIRST NAME	RELATIONSHIP TO CHILD (Check all that apply) ☐Mother ☐Father ☐Legal Guardian ☐Other

Address: ☐Check if same a patient	City	State	Zip
Home Phone ☐Preferred	Cell Phone ☐Preferred	Work Phone ☐Preferred	
Email	Social Security #:	Date of birth (mm/dd/yyyy)	

GENDER	Employer Name	Employer Phone
☐Male ☐Female ☐Other		

EMERGENCY CONTACT (**other than parents**)

LAST NAME	FIRST NAME	Relationship (Please Specify)

Home Phone ☐Preferred	Cell Phone ☐Preferred	May we release protected health information: ☐Yes ☐No

INSURANCE INFORMATION

I HAVE INSURANCE: ☐ YES ☐NO (Self Pay)	**Please present all current insurance cards to the Front Desk**
PRIMARY INSURANCE	SECONDARY INSURANCE

SUBSCRIBER	RELATION	SUBSCRIBER	RELATION
GENDER ☐Male ☐Female		GENDER ☐Male ☐Female	
DATE OF BIRTH (MM/DD/YYYY)		DATE OF BIRTH (MM/DD/YYYY)	

CONFIDENTIAL COMMUNICATION

TELECOMMUNICATIONS- Please leave messages regarding my health information as follows (Check all that apply):	**POSTAL COMMUNICATION**- Pleae mail my protected health information to me at (Select Only One)
☐Home Phone on Record ☐Brief ☐Extended ☐Cell Phone on Record ☐Brief ☐Extended ☐Work Phone on Record ☐Brief ☐Extended	☐Mailing Address on Record ☐Physical Address on Record ☐Other:_____

Custodial Information

Is there a court order preventing either parent from accessing the patient's medical information? ☐YES ☐NO

If YES, please provide us with a copy of the legal document stating parental rights.

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at Hometown Pediatric Care, LLC which outlines my privacy rights and how Hometown Pediatric Care, LLC may use and disclose Protected Health Information about me.

Initials:_____

Telephone Contacts, Monitoring and Recording

I herby consent and agree that I have an established business relationship with Hometown Pediatric Care, LLC and that Hometown Pediatric Care, LLC may contact me at any telephone number I provide to them, whether a residential or business number, a wireless, cellular or mobile number (including a telepone number converted to a mobile/wireless number, or which connects to any type of mobile.wireless device).
I understand that, if I accept now, I may opt-out at any time by notifying the Hometown Pediatric Care, LLC staff.

Initials:_____

Confidential Communications
I understand the Hometown Pediatric Care, LLC will notify me if Hometown Pediatric Care, LLC is unable to comply with my request for Confidential Communications.

Initials:_____

Additional Children in Household

1._____	Date of Birth:_____	Gender:_____
2._____	Date of Birth:_____	Gender:_____
3._____	Date of Birth:_____	Gender:_____
4._____	Date of Birth:_____	Gender:_____
5._____	Date of Birth:_____	Gender:_____
6._____	Date of Birth:_____	Gender:_____

Parent/Legal Guardian PRINTED Name | Parent/Legal Guardian Signature | Date

Updated 12/26/2023-tmw
twells/frontoffice/ptreg2024