Is this your first time seeing us? ☐ YES ☐ NO
How did you hear about us? ____

****If you are a step parent, foster parent, or any other type of guardian; Please fill out number 3 of this form with your information.**

This is the parent we will contact for lab results, confirm appointments, billing questions etc.

1. **Primary Parent Name**____
Address________________________________ City _________________ State _____ Zip ______
Phone number _____-______-______DOB _____-_____-______SSN _______-_______-_______
Email (to be used to access your child's patient portal):
____
Employer ____________________________________ Employer's number _____-______-______

2. **Secondary Parent Name** ____
Address________________________________ City _________________ State _____ Zip ______
Phone number _____-______-______DOB _____-_____-______SSN _______-_______-_______
Employer _____________________________________ Employer's number _____-______-______

3. **Other Guardian's Name** ______________________________Relationship to child___________
Address________________________________ City _________________ State _____ Zip ______
Phone number _____-______-______DOB _____-_____-______SSN _______-_______-_______

If you are not the biological parent; do you have legal custody of the children Yes ☐ No ☐

Does the biological parent have any:
☐ Vision impairment ☐ Hearing impairment ☐ Communication impairment ☐ Unknown

4. **Insurance Information**
Primary Insurance ___________________Policy Holders Name__________________________
DOB _____-_____-_______ SSN ______-_______-________ ID Number _________________
Group Number __________________________________

Secondary Insurance __________________Policy Holders Name _________________________
DOB _____-_____-_______ SSN ______-_______-________ ID Number _________________
Group Number __________________________________

5. **Emergency contact other than the parents/caregiver.**
Name ____
Phone Number _____-______-______ Relationship to child _______________________________

Turn over

Child’s Name ____
☐ Biological child ☐ Step child ☐ Adopted child ☐ Legal guardian of child
DOB ____-_____-_____Sex ___Does this child live with the Primary Parent Yes No
If they do not live with the Primary Parent; please list their address below.
Address______________________________ City ________________ State _____ Zip _______

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report
Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report

Child’s Name ____
☐ Biological child ☐ Step child ☐ Adopted child ☐ Legal guardian of child
DOB ____-_____-_____Sex ___Does this child live with the Primary Parent Yes ☐ No ☐
If they do not live with the Primary Parent; please list their address below.
Address______________________________ City ________________ State _____ Zip _______

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report
Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report

Child’s Name ____
☐ Biological child ☐ Step child ☐ Adopted child ☐ Legal guardian of child
DOB ____-_____-_____Sex ___Does this child live with the Primary Parent Yes No
If they do not live with the Primary Parent; please list their address below.
Address______________________________ City ________________ State _____ Zip _______

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report
Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report

Child’s Name ____
☐ Biological child ☐ Step child ☐ Adopted child ☐ Legal guardian of child
DOB ____-_____-_____Sex ___Does this child live with the Primary Parent Yes No
If they do not live with the Primary Parent; please list their address below.
Address______________________________ City ________________ State _____ Zip _______

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report
Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report

Authorization Section

I Hereby authorize the release of my (or my child’s) medical information to my insurance carrier concerning me or my child’s illness and treatment and hereby assign all payments for medical services to my doctor. I understand that I am responsible for any amount not covered by my insurance. In the event that the collection process becomes necessary, I agree to pay all attorney fees, court costs and collection fees. I also acknowledge that I can access the HIPPA notice for the Medical Center for Children and Adolescents, PA (DBA as The Pediatric Center) on their website, www.mypediatriccenter.com.

Signature: ____ Today’s Date _______________