Pediatric Center

Is this your first time seeing us? ☐ YES ☐ NO
If yes; we would love to say thank you to the person who referred you to us! Please share their info below.
Name: _____Phone #_____
Address (if able):_____

****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.**

The primary parent is the one we will contact for lab results, confirm appointments, billing questions etc. If a child is 18 years old, they will receive their own information sheet.

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 parents have any:
☐ Vision impairment ☐ Hearing impairment ☐ Communication impairment ☐ Unknown

4. **Insurance Information. Please fill out every time you receive this paperwork for our billers records.**
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

Pediatric Center

Please list all of the children that are 17 years old or younger. 18 year olds will receive their own information sheets. If you need more spaces, please let the front desk know.

1. Child's Name _____

In relationship to primary parent: ☐ Biological child ☐ Step child ☐ Adopted 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 Haw aiian/Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report **Language:** ☐ English ☐ Other _____

2. Child's Name _____

In relationship to primary parent: ☐ Biological child ☐ Step child ☐ Adopted 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 Haw aiian/Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report **Language:** ☐ English ☐ Other _____

3. Child's Name _____

In relationship to primary parent: ☐ Biological child ☐ Step child ☐ Adopted 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 Haw aiian/Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report **Language:** ☐ English ☐ Other _____

4. Child's Name _____

In relationship to primary parent: ☐ Biological child ☐ Step child ☐ Adopted 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 Haw aiian/Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report **Language:** ☐ English ☐ Other _____

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 also acknowledge that I can access the HIPP 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 _____

Pediatric Center

At the Pediatric Center, we strive to make sure all of our patients' needs are being met. This Survey is to help us know what other factors may be affecting your wellness. As a Patient Centered Medical Home we have many resources to help our patients meet their everyday needs.

1.Do you have adequate housing for your family?	YES	NO
2. Do you feel you have enough food to feed your family?	YES	NO
3. Do you have access to reliable transportation?	YES	NO
4. Are you able to pay for your families' prescriptions?	YES	NO
5. Would you like to discuss any of these questions further with our care coordinator? If yes, which needs? Any other concerns?	YES	NO

Please list all children that are patients at The Pediatric Center

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Signature: _____ Today's Date _____

Minor Consent Form

Effective July 1, 2024, Idaho passed new limits on Minor Consents. In order to be compliant, we are required to have on file the individuals who you authorize to bring your child to the clinic for an appointment. You are authorizing these individuals to accompany your child(ren) to a visit and authorizing them to give consent for exam and/or treatment options including (but not limited to) x-rays, prescribing medication, immunizations etc.

Please list all children that are patients at The Pediatric Center

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Please list any person allowed to accompany your child(ren) to a visit at The Pediatric Center. If you would like your adolescent to be seen by themselves please ask for a separate form.

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Signature: _____ Today's Date _____