Tots & Teens Patient Information Sheet

First Name: _____Middle Name: _____ Last Name: _____

Birth Date: _____/_____/_____ Sex: ____(M) ____(F) SS#: __ __ __ - __ __ - __ __ __ __

Address: _____

City/State: _____ Zip: _____

Race: _____ Ethnicity: _____

Home Phone#: (____)_____-_____Mother's Cell#: (_____)_____-_____

Father's Cell#: (____)_____-_____Work#: (____)_____-_____

Mother's Name: _____ Birth Date: _____/_____/_____

SS#: ___ ___ ___-___ ___-___ ___ ___ ___ Employer: _____

Father's Name: _____ Birth Date: ____/_____/_____

SS#: ___ ___ ___-___ ___-___ ___ ___ ___ Employer: _____

Siblings:

Name: _____DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Primary Insurance Information:

Insurance Company: _____ ID#: _____

Group #: _____ Subscriber Name: _____

Relationship to patient: _____ Birth Date: _____/_____/_____

SS#: ___ ___ ___-___ ___-___ ___ ___ ___ Address: _____

Insurance continued on next page:

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Secondary Insurance Information: (IF ANY)

Insurance Company: _____ ID#: _____

Group #: _____ Subscriber Name: _____

Relationship to patient: _____ Birth Date: _____/_____/_____

SS#: ___ ___ ___-___ ___-___ ___ ___ ___ Address: _____

Tertiary Insurance Information: (IF ANY)

Insurance Company: _____ ID#: _____

Group #: _____ Subscriber Name: _____

Relationship to patient: _____ Birth Date: _____/_____/_____

SS#: ___ ___ ___-___ ___-___ ___ ___ ___ Address: _____

Third Party Consent

I authorize Tots & Teens, P.A. to communicate with my insurance company to coordinate treatment, to facilitate quality of treatment, and obtain reimbursement. By not signing consent, I am agreeing to full payment at the time of service. Initial: _____

***I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify the information provided is true and correct. I will notify Tots & Teens, P.A. of any changes in the above information, in a timely manner. Initial: _____**

Privacy Practice

I acknowledge that I have been provided access to Tots & Teens OSSMA's notice of privacy practices, and can obtain a copy from the front office at any time requested. Initial: _____

Parent Signature: _____ Date: _____

Tots & Teens Medical Consent & Emergency Contact

Emergency Contact:

First Name: _____ Last Name: _____

Relationship to patient: _____ Phone#: (_____)_____-_____

Authorized Individuals:

Please list individuals other than parent/guardian authorized to bring patient in for medical treatment

1) **First Name: _____ Last Name: _____**
   Relation: _____ Phone#: (____)_____-_____

2) **First Name: _____ Last Name: _____**
   Relation: _____ Phone#: (____)_____-_____

3) **First Name: _____ Last Name: _____**
   Relation: _____ Phone#: (____)_____-_____

***Please be aware only those names listed on the consent can bring your child to an appointment. If an individual other than those listed above brings in the child, we will reschedule the appointment unless a written consent is sent in and signed by parent/guardian.**

I _____, authorize the above individual(s) to bring my child to any doctor's appointments and make medical decisions on my behalf.

Regarding Minor Patients

A parent or legal guardian MUST accompany all minor patients under the age of 18 years to each visit.

Patient Name: _____ Birth Date: _____/_____/_____

Parent Signature: _____ Date: _____/_____/_____

GENERAL OFFICE POLICIES

*Parents are responsible for accurate and up to date insurance information and immunization records. Please bring your insurance information for each visit.

*Please notify our staff of changes to address, telephone work or cell phone numbers.

*Please alert our staff on arrival of temperature>103, difficulty breathing/wheezing or suspected Chicken Pox.

*We ask you to arrive on time for your appointment. Please be aware that your appointment time may not reflect the actual time you are seen by the doctor.

*Patients that arrive more than 10 min late to a sick or follow up appointment may be rescheduled.

*We do not allow grace periods for new patients, physicals and ADD/ADHD visits. Please arrive 10-15 min before scheduled time. If late for your schedule appointment time, we will need to reschedule your appointment.

*Aggressive, confrontational behavior or the use of foul language (cursing) in our office will not be tolerated and is subject for dismissal from our practice.

*For security purposes a copy of photo ID for either parents or guardians are required.

*Additional fee of $10 will be charged for any paperwork requiring a provider's signature outside of a scheduled appointment.

NO SHOW/CANCELLATION PROCESS

*A no show is defined as missing a scheduled appointment without calling in advance to cancel.
*A patient who no shows three times within a 6 month period is subject to dismissal from the practice.
*After the third no show, a letter will be mailed requesting that the patient find a new primary care physician.
*We understand that the situations occasionally arise when an appointment cannot be kept, and adequate notice is not possible. These situations will be considered on a case to case basis.

Patient Name: _____ DOB: _____

Parent signature: _____ Date: _____

PLEASE UNDERSTAND THAT THE INTENT OF THESE POLICIES IS TO AID US IN OFFERING A HIGH STANDARD OF CARE TO OUR PATIENTS. THEY ARE NOT MEANT TO BE A BURDEN. WE ALSO PLEDGE TO DO OUR PART TO KEEP OUR SCHEDULE MOVING AS EFFICIENTLY AS WE POSSIBLY CAN.