Park Ridge Pediatrics PC Information Sheet-**PLEASE PRINT CLEARLY**

PATIENT NAME_____ DATE OF BIRTH_____

OTHER CHILDREN_____ DATE OF BIRTH_____

_____ DATE OF BIRTH_____

_____ DATE OF BIRTH_____

INSURANCE HOLDER'S INFORMATION

NAME_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ ST_____ ZIP_____

PHONE: DAD CELL_____ MOM CELL_____ OTHER_____

EMAIL (BEST ONE)_____

RELATIONSHIP TO PATIENT_____ OTHER PARENT NAME_____

INSURANCE INFORMATION--**PLEASE GIVE CARD TO FRONT DESK TO SCAN COPY**

PRIMARY_____ SECONDARY_____

EMPLOYER_____

IF YOU DO NOT NOTIFY THE OFFICE OF AN INSURANCE CHANGES, YOU MAY BE RESPONSIBLE FOR ANY BALANCE!

ETHNICITY-CIRCLE ONE

HISPANIC

NON HISPANIC

PREFER NOT TO ANSWER

RACE-CIRCLE ONE

WHITE

AFRICAN AMERICAN/BLACK

ASIAN

NATIVE AMERICAN

NATIVE HAWAIIAN

MIXED

PREFER NOT TO ANSWER

PREFERRED PHARMACY

NAME_____ ADDRESS_____

TOWN_____ PHONE_____

I UNDERSTAND THAT PARK RIDGE PEDIATRICS DOES NOT DELAY OR SEPARATE REQUIRED VACCINATIONS (UNLESS ACTIVELY SICK)

SIGNATURE_____ DATE_____

PARENT/GUARDIAN RELATIONSHIP TO PATIENT

Park Ridge Pediatrics PC **NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about your child may be used and disclosed and how you can get access to the information. Please review it carefully and sign below. Please ask front desk if you have any questions or concerns.

I have read and understand the Park Ridge Pediatrics PC, Notice of Privacy Practices

_____ _____

INITIALS of Parent/Legal Guardian/Legal Representative Date

PRESCRIPTION MEDICATION CONSENT FORM

The Providers at Park Ridge Pediatrics PC use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and your specialists, we ask that patients allow us to access their medication history through Rx Hub.

Please check one of the following

☐ I consent to allow my provider to access all of my child' s medication history

☐ I DO NOT consent to my provider accessing any of my child's medication history

Printed Name_____

_____ _____

INITIALS of Parent/Legal Guardian/Legal Representative Date

All patients and visitors will be respectful and use appropriate language and behavior. Physical or verbal threats or assaults, suggestive or explicit words, phrases or gestures will not be tolerated. All patients and visitors will respect patient privacy and avoid disrupting another patient's care or experience. Videos or photography are not permitted at Park Ridge Pediatrics.

Thank you

INITIAL HERE: _____

A NO SHOW fee of $25 will be billed directly to you if you do not give us 24 hrs notice prior to the cancellation of your scheduled appointment. We understand that an illness or emergency make occur, but please try to call as soon as you know that you will not be able to keep your appointment!
There will be a $20 charge for after-hour non-emergency phone calls to our RN Nursing Answering Service.

Thank you

INITIAL HERE: _____