FAMILY/PATIENT INFORMATION SHEET – 2016

Legal Guardian #1: ***Relationship to Patient (circle one) Mother / Father / Other:*** _____

Name: _____
Last First Middle Initial

Home Address: _____
Street City State Zip Code

Date of Birth: Month_____ Day_____ Year_____ County: _____

Primary Phone #: (____) _____ (*Home /Cell)* Alternate Phone # (____) _____ (*Home/Cell)*

Marital Status (circle one): Married Divorced Domestic Partner Separated Widowed Single

Employer: _____ Occupation: _____

Legal Guardian #2: ***Relationship to Patient (circle one) Mother / Father / Other:*** _____

Name: _____
Last First Middle Initial

Home Address: _____
Street City State Zip Code

Date of Birth: Month_____ Day_____ Year_____ County: _____

Primary Phone #: (____) _____ (*Home /Cell)* Alternate Phone # (____) _____ (*Home/Cell)*

Marital Status (circle one): Married Divorced Domestic Partner Separated Widowed Single

Employer: _____ Occupation: _____

- **Who may we thank for referring you to our practice?** _____

Preferred E-Mail: _____ **Cell Number:** _____

Authorization to Receive E-Mail Blasts, Newsletters and Appointment Reminder(s) via E-Mail and/or Text

Child: _____
First Name Middle Initial Last Name Birthdate

Child: _____
First Name Middle Initial Last Name Birthdate

Child: _____
First Name Middle Initial Last Name Birthdate

Child: _____
First Name Middle Initial Last Name Birthdate

PLEASE COMPLETE BACK OF FORM →

APPOINTMENT POLICY

You are required to give our office at least 24 hours' notice prior to your appointment time if you are unable to keep an appointment. This not only gives another patient the opportunity to be seen but also allows our support staff to utilize their time most effectively.

Appointments require time and preparation resources of both the physician and the support staff. Our schedule is designed to accommodate the needs of both our well and sick patients.

Any missed appointment will result in a $50.00 fee charged to your account. We understand emergencies can come up. Please let us know immediately when you are unable to keep an appointment due to unexpected circumstances.

We appreciate your understanding and acknowledgement of this policy.

EMERGENCY CONTACT (NOT LIVING WITH PATIENT)

Name:_____ Relationship to Patient_____ Phone Number: _____

FINANCIAL ARRANGEMENTS AND INSURANCE

Co-payments are due at the time services are rendered. We accept cash, check, MasterCard, Visa and Discover.

If you have medical insurance, Arlington Pediatrics, Ltd. will submit claims directly to your insurance company. Your insurance is a contract between you, your employer and the insurance company. Arlington Pediatrics, Ltd. is not a party to that contract. Not all services are a covered benefit in all contracts, and it is your responsibility to be aware of what benefits your insurance entitles you to. We will assist you to receive your maximum allowable benefits.

We emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your patient due balance. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account.

By signing below, I agree and understand all of the above statements regarding financial arrangements and insurance. I authorize payment of medical benefits directly to Arlington Pediatrics, Ltd.

_____

Signature of Parent/Guardian ***Date***

AUTHORIZATION TO TREAT

We recognize there may be occasions when neither parent (or guardian) is available to bring their child(ren) to our office. Your signature below will allow us to provide care for your child(ren) in your absence. Otherwise we will need to obtain your written permission prior to caring for your child(ren) for each occasion of your absence.

I authorize the doctors of Arlington Pediatrics, Ltd. to provide medical care and treatment for my child(ren) in my absence, including but not limited to routine examinations, immunizations and lab tests.

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Signature of Parent/Guardian ***Date***