Charles Towne
PEDIATRICS
care for kids at every stage

## Patient Information

Last Name:_____ First Name:_____

Middle Initial:_____ Date of Birth:___/___/_____ Sex: Male___ Female___ SSN:_____-_____-_____

Address:_____City:_____ State: ____ Zip:_____

Email Address: _____

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

May we leave a message about appointments and/or normal test results on the phone number you provided?

Yes_____ No_____

Primary Care Physician:_____ Referred by: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Primary Language: English Spanish French Other:_____

Race: Caucasian African American Asian Other:_____

Student Status: Not a Student Full Part

Employee Status: N/A Full Part Employer:_____

Pharmacy Name:_____ Address:_____ Phone: ( )_____

Emergency Contact: Name:_____ Relationship:_____

Phone Number: ( )_____

Alternate Contact: If you want this Practice to contact you at an alternate address or phone number, please complete:

Alt Address:_____ City:_____ State:_____ Zip:_____

Phone: ( )_____ Cell Phone:( )_____

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## Parent Information

**Mother:** Last Name:_____ First Name:_____ Middle:____

Date of Birth:___/___/_____ Age:____ SSN:_____ Mrs. Miss Ms.

Address(if different from patient):_____ City:_____State:_____ Zip:_____

Home Phone:( )_____ Cell Phone:( )_____ Work Phone:( )_____

Financially Responsible: Yes No

**Father:** Last Name:_____ First Name:_____ Middle:_____

Date of Birth:___/___/_____ Age:____ SSN:_____

Address(if different from patient):_____ City:_____State:_____ Zip:_____

Home Phone:( )_____ Cell Phone:( )_____ Work Phone:( )_____

Financially Responsible: Yes No

**Other:** Last Name:_____ First Name:_____ Middle:_____

Date of Birth:___/___/_____ Age:____ SSN:_____ Mrs. Miss Ms. Mr.

Address(if different from patient):_____ City:_____State:_____ Zip:_____

Home Phone:( )_____ Cell Phone:( )_____ Work Phone:( )_____

Financially Responsible: Yes No

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**Primary Insurance:**

Insurance Company:_____

Policyholder Name:_____

Member ID:_____

Policyholder Date of Birth:___/___/_____

Insurance Co. Phone #: ( )_____

Group Number:_____

Relationship to Patient:_____

**Secondary Insurance:**

Insurance Company:_____

Policyholder Name:_____

Member ID: _____

Policyholder Date of Birth:___/___/_____

Insurance Co. Phone #: ( )_____

Group Number:_____

Relationship to Patient: _____

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For ongoing communication regarding your Healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service.

**For patients under the age of 18: If anyone other than a parent or guardian will be bringing your child in, they must be listed here in order for this practice to see and discuss health information with them.**
*For example, you may list family members, friends, or other caregivers.*

From Date of Service:_____ To Date of Service:_____

| Name of Person | Address | Phone/Fax | Relationship to Patient |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

An **Authorization to Release Information Form** must be completed for all releases and disclosures not listed in the section below.

**A Request For Restrictions Form must be completed to request restrictions of the use of your information.**

I consent to the treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPPA and as described in the Liberty Doctors, LLC. Notice of Information Practices, which a copy has been made available to me.

I understand that my medical information may including complete medical records and, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Liberty Doctors, LLC. for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name:_____

Patient's Signature (unless minor):_____ Date: ___/___/_____

Print Legal Guardian's Name:_____

Legal Guardian's Signature:_____ Date: ___/___/_____