Patient information

Last Name_____ First Name_____MI____Suffix_____

Address_____City_____ State_____Zip_____

Primary Phone Number( ) _____-_____ Secondary ( )_____-_____

DOB_____/____/_____ Sex M( ) F( ) SSN_____-_____-_____

Race ( )African American ( ) Asian ( )Caucasian ( ) Multiracial ( )Other

Ethnicity ( )Non-Hispanic ( ) Hispanic Language _____

Primary Responsible Parent/Party

Relationship to the Patient:_____

Last Name_____ First Name_____MI____Suffix_____

DOB_____/____/_____ SSN_____-_____-_____ Sex M( ) F( )

Primary Phone Number( ) _____-_____ Secondary ( )_____-_____

Address_____City_____ State_____Zip___

E-Mail_____@_____.com

Employer Name_____Work phone number ( )_____-_____

Ok to leave a message at work? ( ) Yes ( ) No

Secondary Responsible Parent/Party

Relationship to the Patient:_____

Last Name_____ First Name_____MI____Suffix_____

DOB_____/____/_____ SSN_____-_____-_____ Sex M( ) F( )

Primary Phone Number( ) _____-_____ Secondary ( )_____-_____

Address_____City_____ State_____Zip___

E-Mail_____@_____.com

Employer Name_____Work phone number ( )_____-_____

Ok to leave a message at work? ( ) Yes ( ) No

Pharmacy Information

Name of Preferred Pharmacy_____City_____ Zip_____

Name Secondary Pharmacy _____City_____ Zip_____

Primary Insurance information

Primary Insurance_____

Member ID #_____Group #_____Copay$_____

Subscriber Name_____Relationship to Patient_____

Secondary Insurance Information

Primary Insurance_____

Member ID #_____Group #_____Copay$_____

Subscriber Name_____Relationship to Patient_____

Emergency Contacts & Authorized to Bring in For Medical Services

Name_____ Relationship to Patient_____

Phone:( )_____-_____Phone:( )_____ -_____

Name_____ Relationship to Patient_____

Phone:( )_____-_____Phone:( )_____ -_____

Date HIPAA information was given _____

Authorization to access RX history information: yes ( ) no ( )

I herby authorize Kidz Biz Pediatrics to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

I herby authorize direct payment of Surgical/Medical Benefits to Dr. Daniel Rudolph and Dr. Joshua Boldt for services rendered by them in person or care under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I herby authorize my child to be treated by Dr. Daniel Rudolph, Dr. Joshua Boldt or persons under their supervision.

I herby authorize Kidz Biz Pediatrics to release any medical or incidental information that may be necessary for their medical care or in process in applications for medical benefit.

Signature of Responsible Parent/Party_____Date_____

Signature for ResponsibleParent/Party_____Date_____

Relationship to Patient_____