



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 () _____ - _____

Permission to leave a message regarding PHI (Protected Health Information)? () Yes () No

Permission to participate in Patient Portal (Healow) () 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 _____

Employer Name _____ Work phone number () _____ - _____

Permission to leave a message regarding PHI (Protected Health Information)? () Yes () No

Primary Insurance Information

Primary Insurance _____

Member ID # _____ Group # _____ Copay\$ _____

Subscriber Name _____ Relationship to Patient _____

Secondary Insurance Information

Secondary Insurance _____

Member ID # _____ Group # _____ Copay\$ _____

Subscriber Name _____ Relationship to Patient _____

Pharmacy Information

Name of Preferred Pharmacy _____ City _____ Zip _____

Name Secondary Pharmacy _____ City _____ Zip _____

Date HIPAA information was given _____

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

Emergency Contacts & Authorized to Bring in For Medical Services

Name _____ Relationship to Patient _____

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

Permission to discuss PHI with emergency contact? ()Yes ()No

Name _____ Relationship to Patient _____

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

Permission to discuss PHI with emergency contact? ()Yes ()No

Protected Health Information consists of your child's medical information (e.g. lab or test results, prescriptions, treatment).

The portal allows you the ability to communicate with KBP in regards to appointment requests, medication refill requests, and allows bidirectional communication between you and your providers and allows them to personally inform you regarding labs and other test results, all on a secured line.

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

I hereby 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 _____