Spring Creek PEDIATRICS

Date: _____ **PATIENT DEMOGRAPHICS**

This is a **YEARLY** form.
Please add children who live in your household and are patients.
We are **required** to have Parent or Legal Guardian's signature on file.

	FULL NAME	DATE OF BIRTH	GENDER	
1.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
2.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
3.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
4.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____

(If you have more than 4 to list, please ask front for page 3)

PRIMARY CONTACT/GUARANTOR *(Person Responsible for Payment)*
Name: _____ D.O. B ___/___/_____ SSN: _____ ***(Required by Insurance)***
Address: _____ City:_____ State:_____ Zip:_____
Primary Phone: (_____) _____Email:_____
Relationship to patient? _____

SECONDARY CONTACT
Name: _____ D.O. B ___/___/_____ SSN: _____*(Required by Insurance)*
Address: _____ City:_____ State:_____ Zip:_____
Primary Phone: (_____) _____Email:_____
Relationship to patient? _____

WHO DOES CHILD LIVE WITH? _____
If Divorced or Separated, who is the Custodial Parent? _____***PLEASE NOTE: LEGAL DOCUMENTATION WILL BE REQUIRED.***

PRIMARY INSURANCE INFORMATION ***Applicable)***
Policy Holder Name: _____
Policy Holder Birthday: ____/____/_____
Policy Holder SSN: _____
(This is REQUIRED for insurance verification and billing)
Employer: _____
Insurance Company: _____
Policy/Member ID #: _____
Group ID #: _____
Effective Coverage Date: _____
_____

SECONDARY INSURANCE INFORMATION ***(If***
Policy Holder Name: _____
Policy Holder Birthday: ____/____/_____
Policy Holder SSN: _____
(This is REQUIRED for insurance verification and billing)
Employer: _____
Insurance Company: _____
Policy/Member ID #: _____
Group ID #: _____
Effective Coverage Date:

EMERGENCY CONTACT
(Person other than parents, Grandparent, Aunt, Uncle, Family Friend)

Name: _____ Phone Number: (_____) _____
Relation: _____

Names of Those (Non-Parent, Non-Guardian) that has permission to bring the Child/Children:

***If parent or legal guardian is not present OR if child is 16+, we still have to have verbal consent by phones to give vaccines.*

Name: _____Relation: _____
Name: _____Relation: _____

PHARMACY INFO
Pharmacy Name: _____
Pharmacy Address: _____
City: _____State: _____ Zip: _____
Pharmacy Phone Number: (_____)_____

NOTICE OF PRIVACY

By my signature, I have been made aware of the SPRING CREEK PEDIATRICS' HIPAA Privacy Regulations. A synopsis of the manual is posted and available upon written request. A copy of the Federal Laws Governing the Protected Health Information (PHI) may be downloaded by going to https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

I understand that as part of my child's care, SPRING CREEK PEDIATRICS originates and maintains paper and or electronic records describing their health history, symptoms, exams, test results, diagnosis, treatments, and plans for future care or treatment.
I Authorize the release of any office notes and results of images in the event it is needed to help with the diagnosis and plan of care for further treatment in coordination of care for my child. I permit a copy of this information to be used in place of the original.

ACCOUNT AND INSURANCE POLICY

Thank you for choosing SPRING CREEK PEDIATRICS to care for your child(ren). We are committed to providing the best care possible. Understanding your financial responsibility is considered part of your medical management. This Financial Policy is an agreement between you and the providers of SPRING CREEK PEDIATRICS. Your understanding is important to our professional relationship.

It is important for you to be an informed consumer who understands the specifications of your insurance policy (*e.g.*, vaccine and doctor visit coverage and referral/ authorization requirements for specialty care) Insurance plans vary considerably. We cannot predict or guarantee what part of our services will or will not be covered. It is your responsibly to provide SPRING CREEK PEDIATRICS with **accurate** and **timely** insurance information. Inaccurate or untimely information that results in denial or non-coverage by your insurance company will be your responsibly.

I acknowledge that during my **child's wellness visit**, there may be a **problem-oriented service** performed by SPRING CREEK PEDIATRICS provider. In this case, I understand that **two separate charges may be submitted** to my insurance and that **when applicable, a copay/deductible/co insurance may be required for charges generated pertaining to problem-oriented services.** Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my copay /deductible would still apply.

NON-EMERGENCY APPOINTMENTS may be rescheduled if your child's account has an outstanding balance(s) or if a co-payment is not paid at time of service. We accept cash, checks, MasterCard, AmEx, Visa, or Discover.

Outstanding balances are due within 30 days, unless prior arrangements have been made with SPRING CREEK PEDIATRICS' BUSINESS OFFICE.

CONTACT INFORMATION

May we leave a message on your voice mail or text your cell phone regarding your child's appointment reminders, any test results, referral, account information etc. **Y / N**

X _____ Date: _____
Signature of Parent or Legal Guardian of Minor Child/ Children

_____

Printed Name of Parent or Legal

This form must be completed in FULL

Revised 11.2024

5+ Children Demo Page

	FULL NAME	DATE OF BIRTH	GENDER	
5.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
6.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
7.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
8.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____
9.)	_____	___/____/____	M / F/ Other	Patient's # if 16+ _____
10.)	_____	___/____/____	M / F/ Other	Pt's cell # if 16+ _____