Pediatric Care, Inc.
800 Compton Road, Suite 25 Cincinnati, Ohio 45231
8752 Union Centre Blvd. West Chester, Ohio 45069

Name of Child **(Please Print)** **Date_____**

Last Name	First Name	Middle	Sex	Date of Birth MM/DD/YYYY	Primary Language	Race	Ethnicity H = Hispanic or Latino N = Not Hispanic or Latino D = Decline
			M/F	__/__/___			H / N / D

Patient Address_____City_____ST_____Zip_____

Emergency Contact Other Than Parents

Name_____Relationship_____Phone Number_____

Preferred Pharmacy

Pharmacy Name_____ Address _____Phone Number_____

Which provider do you prefer to see at Pediatric Care, Inc.? *Please Circle*

Dr. Delsignore Dr. Hein Dr. Kopp Dr. Partusch Kristen Curington, NP Amy Valerius, NP

Parent/Guardian #1	**Parent/Guardian #2**
Name	Name
Birthdate SSN	Birthdate SSN
Relationship to Patient	Relation to Patient
Child's Biological Parent? Yes or No	Child's Biological Parent? Yes or No
Does Patient reside with you? Yes or No *If answered "No," please complete address below*	Does Patient reside with you? Yes or No *If answered "No," please complete address below*
Address	Address
City ST Zip	City ST Zip
Email Address *(Required for Portal Access)*	Email Address *(Required for Portal Access)*
Primary Number ( ) Home/Cell/Work	Primary Number ( ) Home/Cell/Work
Secondary Number ( ) Home/Cell/Work	Secondary Number ( ) Home/Cell/Work
Preferred Language	Preferred Language
Occupation	Occupation
Employed by	Employed by

(If more than two contacts, please list on the back)

Who should be contacted by our office regarding appointments, general notifications, or portal reminders?

Both Parents/Guardians or Parent/Guardian #1 or Parent/Guardian #2

How should the above person(s) be contacted?

General/Appt Reminders/Recalls: Text / Call / Email Portal Reminders: Text / Email

Parent/Guardian Signature_____

If parents are divorced or separated, please fill out this section:

Are there any **legal restrictions** that would restrict the non-custodial parent from consenting to medical treatment for the child or from providing or obtaining information about the child's medical treatment? **YES / NO**

*If yes, please explain **and** provide a copy of any legal paperwork that supports this restriction.*

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Yearly Financial Update

(Please Print)

List all names of children currently patients of Pediatric Care

Child's Name	DOB:
Child's Name	DOB:
Child's Name	DOB:
Child's Name	DOB:
Child's Name	DOB:
Child's Name	DOB:

Insurance Information

(Please complete and furnish us with a copy of your insurance card.)

NOTE: Patients who carry health insurance should remember that payment for our services is the responsibility of the insured, and patients are expected to pay their co-pay at the time of service. Any balance not covered by insurance is due and payable upon receipt of billing statement.

Primary Insurance	**Secondary Insurance**
Name of Insured	**Name of Insured**
DOB:	**DOB:**
Relationship to Patient	**Relationship to Patient**
ID # **Group#**	**ID #** **Group#**

Please read and initial each line. If you have questions, please ask the front desk for assistance.

1. _____ In the event that the parent(s)/legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize the physicians at Pediatric Care, Inc. to evaluate and treat any and all conditions that require immediate attention.

2. _____ ACKNOWLEDGEMENT OF RECEIPT: I hereby acknowledge that I have received the Notice of Privacy Practices of Pediatric Care, Inc. I understand this notice contains information regarding how Pediatric Care, Inc. uses my medical information.

3. _____ FINANCIAL POLICY: I have received a copy of Pediatric Care, Inc.'s Financial Policy and understand and agree to the conditions outlined in the policy.

4. _____ Pediatric Care ultimately holds both parents responsible for payment unless court documents are provided stating otherwise. In circumstances where the parents are separated or divorced, Pediatric Care will not act as a mediator in collecting our payments.

5. _____ FAILED AND CANCELLED APPOINTMENT POLICY**:** I understand the office requires 24 hour in advance notification if I am unable to keep or need to reschedule an appointment. Failure to provide sufficient notice may result in a **missed appointment fee** of up to **$50.00** per patient.

ASSIGNMENT AND RELEASE: I hereby authorize Pediatric Care, Inc., to treat and furnish information to insurance carriers concerning treatment. I hereby assign to the provider all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. Additionally, Pediatric Care, Inc. has my permission to make reasonable disclosures of my children's Personal Health Information to parents, schools, doctors, and others involved in their care, unless otherwise specified.

I agree to allow Pediatric Care, Inc. to send me automated text messages to the number I have provided for appointment and scheduling reminders, appointment cancellations, office closures etc.

Parent's Signature:_____Date_____