GADSDEN PEDIATRIC CLINIC

501 BAY STREET • GADSDEN, ALABAMA 35901

PATIENT - FAMILY INFORMATION

PATIENTS: (List All Children)	Social Security Number	Birthdate	Sex
_____	_____	_____	❑ M ❑ F
_____	_____	_____	❑ M ❑ F
_____	_____	_____	❑ M ❑ F
_____	_____	_____	❑ M ❑ F
_____	_____	_____	❑ M ❑ F
_____	_____	_____	❑ M ❑ F

Patient lives with: _____ Zip _____

FATHER/GUARDIAN

Full Name _____
Address _____
City/State/Zip _____
Home Phone _____
Cell Phone _____
Place of Employment _____
Work Phone _____
Social Security Number _____
Date of Birth _____
Driver's License Number _____

MOTHER/GUARDIAN

Full Name _____
Address _____
City/State/Zip _____
Home Phone _____
Cell Phone _____
Place of Employment _____
Work Phone _____
Social Security Number _____
Date of Birth _____
Driver's License Number _____

Emergency Contact / Telephone: _____

Thank you for choosing Gadsden Pediatric Clinic for your child's health care. As pediatricians, we want to provide your child the best care possible. Our recommendations for health supervision follow the guidelines of the American Academy of Pediatrics. There may be certain routine services that we feel are necessary for the maintenance of good health that are not covered by your insurance contract. You will be expected to pay for these services in full. If you have any questions about whether a particular service is covered or not, the benefits office of your health plan should be happy to assist you.

I, the undersigned parent (or guardian) of the above children, authorize Drs. McCorkle, Nagji, Quizon, Lockridge, Yother, Hill, Gibson, and Tiffany Sweatt, CRNP, to give any necessary treatment or immunization to my child when brought by myself or another responsible party, or if teenager, when alone.

I authorize the release of any information necessary for the filing of insurance claims and hereby assign to Gadsden Pediatric Clinic, P.A. all benefits for services rendered.

I understand that regardless of insurance coverage, I am responsible for my account, and my account is to be paid in full within 30 days. I also understand that if this account is referred to an attorney that I will pay all costs of collection and enforcement, including reasonable attorney fees.

Information Privacy: Gadsden Pediatric Clinic, P.A. has prepared a detailed NOTICE OF PRIVACY PRACTICES to help me better understand how health information is shared. Gadsden Pediatric Clinic, P.A. will use and disclose my child's health information for treatment, to obtain payments for health care services and for other health care operations. I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____