

Patient	Name (Last, First MI): _____ Name patient likes to be called: _____									
	Date of Birth: ____/____/____		Primary Care Physician: _____							
	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Patient Declined									
	Race: ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Patient Declined									
	Gender Identity: ☐ Male ☐ Female to Male ☐ Non Binary ☐ Decline ☐ Female ☐ Male to Female ☐ Other: _____									
	Interpreter Needed: ☐ No ☐ Yes Language Preference: _____									
	Address: _____									
	City: _____ State: _____ Zip: _____									
	Patient Home Phone: _____ Cell Phone: _____ Email: _____									
	Emergency Contact (other than parent/guardian): <table><tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>Name</td><td>Relationship to patient</td><td>Home Phone</td><td>Work Phone</td></tr></table>			_____	_____	_____	_____	Name	Relationship to patient	Home Phone
_____	_____	_____	_____							
Name	Relationship to patient	Home Phone	Work Phone							
Referral Source: ☐ Family Member ☐ Friend ☐ Coworker ☐ Hospital/ER ☐ Website ☐ Internet Search ☐ Physician Referral ☐ Insurance Company ☐ Medicaid ☐ Other: _____										
Preferred Pharmacy: Name: _____ Phone: _____ Address: _____										

Parent/Guardian	Parent 1: _____ Last First MI					
	Date of Birth: ____/____/____					
	SSN: _____					
	Address: ☐ Same as patient _____					
	City State Zip					
	Home Phone: _____					
	Cell Phone: _____					
	Email: _____					
	Employer: _____					
	Occupation: _____					
Insurance	Primary Insurance _____ Insurance Company _____ Claim Address _____ Phone Number Subscriber: _____ Subscriber Address: _____ _____ Subscribers Birth Date: ____/____/____ Relationship to Patient: _____ ID#: _____ Grp#: _____ Copay: _____ Effective Date: ____/____/____			Secondary Insurance _____ Insurance Company _____ Claim Address _____ Phone Number Subscriber: _____ Subscriber Address: _____ _____ Subscribers Birth Date: ____/____/____ Relationship to Patient: _____ ID#: _____ Grp#: _____ Copay: _____ Effective Date: ____/____/____		

I hereby authorize The Children’s Clinic, P.C. to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I authorize The Children’s Clinic to recognize me as a participant of the Patient-Centered Primary Care Home Program*. I also assign The Children’s Clinic all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I understand insurance copays are due at time of service. I have received a copy of the current Privacy Notice and Notice of Referral Rights & Financial Interest of The Children’s Clinic.

Signature: _____ Date _____

*For additional information on the Patient-Centered Primary Care Home Program, please see any staff member.

