PATIENT INFORMATION FORMS

Referred by: Website Friend/Family OBGYN Insurance Walk-In:

PATIENT'S INFORMATION

Name: ____
Last First MI

Race/Ethnicity:
- Caucasian
- Hispanic/Latin
- African American
- Asian
- American Indian/Alaskan Native
- Native Hawaiian
- Pacific Islander
- **E**-Other_________

Date of Birth _______________ • Check if minor (less than 18) **Gender:** • M • F

PATIENT'S INFORMATION

Name: ____
Last First MI

Race/Ethnicity:
- Caucasian
- Hispanic/Latin
- African American
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- **E**-Other_________

Date of Birth _______________ • Check if minor (less than 18) **Gender:** • M • F

PATIENT COMMUNICATION SETTINGS

Preferred Language: ☐ English ☐ Spanish ☐ Other

Enable: ☐ Voice ☐ SMS/ Text ☐ Email

Preferred Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Type of Reminders: ☐All ☐ Appointments ☐ Lab/DI Results

☐ Health Maintenance ☐ Rx Confirmation ☐ General Notification

Preferred Phone # _________________________ Preferred Email: ______________________________

INSURANCE INFORMATION

Primary Insurance Company: ____________________________________ **Name of Person Insured:** _____________________

Policyholder's DOB ______________ **Gender:** • M • F **SSN #** __________________ **Employer:** _________________________

Patient **Relationship:** • Self • Child • Stepchild • Spouse • Other_________________________ **Employer Phone:** ____________________

Policy ID# _________________________ **Group #** _______________________ **Group Name** ___________________________

Secondary Insurance Company: ___________________________________ **Name of Person Insured:** ____________________

Policyholder's DOB ______________ **Gender:** • M • F **SSN #**__________________ **Employer:** ___________________________

Patient **Relationship:** • Self • Child • Stepchild • Spouse • Other_____ **Employer Phone:** ______________________

Policy ID# ____________________________ **Group #** _______________________ **Group Name** ____________________________

MOTHER'S OR GUARDIAN INFORMATION

Last Name: ____ **Marital Status:** • Single • Married • Divorced • Widowed • Separated
Last First MI

Address: ____**City:** ______________________ **State:** ___________ **Zip:** _________

Date of Birth _____________ **Gender:** • M • F **Soc. Sec. #** __________________ **Language:** • English • Spanish • Other______________

Home Phone: _________________ **Cell Phone:** _________________ **Email Address:** _______________________________________

FATHER'S OR GUARDIAN INFORMATION

Last Name: ____ **Marital Status:** • Single • Married • Divorced • Widowed • Separated
Last First MI

Address: ______________________________________**City:** ______________________ **State:** ___________ **Zip:** _________

Date of Birth _____________ **Gender:** • M • F **Soc. Sec. #** __________________ **Language:** • English • Spanish • Other______________

Home Phone: _________________ **Cell Phone:** _________________ **Email Address:** _____________________________________

Patient Name: ______________________________ **DOB:** ______________

Patient Name: ______________________________ **DOB:** ______________

Patient Name: ______________________________ **DOB:** ______________

EMERGENCY CONTACT INFORMATION

Name of Closest Relative Not Living with You: ______________________________

Relationship to Patient: ______________________________**Phone #:** ______________

CONSENT TO TREAT

I Hereby authorized NPS to provide such medical services necessary, either regular or emergency, as may be determined to be in the best interest of the patient, who is a minor. This authorization shall continue and be in full force and effect until revoked in writing by me.

The following individuals and/ or agencies are hereby authorized to accept and sign treatment for and on behalf of my minor child.

Full Name: ______________________ **Relationship:** ______________________

Full Name: ______________________ **Relationship:** ______________________

Full Name: ______________________ **Relationship:** ______________________

______________________________ ______________________

Signature of Parent/Legal Guardian or Representative Date

PHARMACY OF CHOICE

For your convenience, NPS has the ability to submit your prescriptions via electronic prescribing or if you prefer, we can provide you with a paper prescription.

Name of Pharmacy: ______________________ Telephone #: ______________

Address or Cross Streets: ______________________________

I hereby authorize the above pharmacy to transmit information through electronic prescribing. This authorization shall continue and be in full force and effect until revoked in writing by me.

______________________________ ______________________

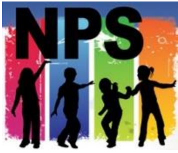
Signature of Parent/Legal Guardian or Representative Date

PHARMACY OF CHOICE

I hereby consent to NPS retrieving my prescription history from external sources. This authorization shall continue and be in full force and effect until revoked in writing by me.

______________________________ ______________________

Signature of Parent/Legal Guardian or Representative Date



Nevada Pediatric Specialists
3201 S. Maryland Parkway suite 608
Las Vegas, NV 89109
Phone:702-457-5437
Fax:702-464-5801

Authorization for Release of Medical Records

PATIENT INFORMATION (Please Print)

Patient's Full Name: ____________________ **DOB:** ____________

Patient's Full Name: ____________________ **DOB:** ____________

Patient's Full Name: ____________________ **DOB:** ____________

Parent/Guardian Name: ____________________ Phone # ____________

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

From:

Physician's Name: ____________________

Name of Practice: ____________________

Practice Phone # ____________ Practice Fax # ____________

To:

Nevada Pediatric Specialists
3201 S. Maryland Parkway suite 608
Las Vegas, NV 89109
Phone:702-457-5437
Fax:702-464-5801

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory and diagnostic test.

By my signature, I authorize the release of all medical records, I understand and accept the terms of the authorization to release my protected health information (PHI)

____________________ ____________
Signature of Parent/Legal Guardian or Representative Date