Penguin Pediatrics PLLC

Child's Name ____

Date of Birth ________/_______/_______ Sex: M F (Check one)

Home Phone (________)_______-_______

Mother's Name ______________________________ Cell Phone (_________)_______-___________

Date of Birth ________/_______/_______ SSN: _____-_____-_______

Home Address ____

City/State/Zip ____

Employer ____

Work Phone (________)_______-_______ E-mail ______________________________

Father's Name ______________________________ Cell Phone (_________)_______-___________

Date of Birth ________/_______/_______ SSN: _____-_____-_______

Home Address ____

City/State/Zip ____

Employer ____

Work Phone (________)_______-_______ E-mail ______________________________

Other children in our practice:

Name ______________________________ Date of Birth ___________/_______/_______

Name ______________________________ Date of Birth ___________/_______/_______

Name ______________________________ Date of Birth ___________/_______/_______

Emergency Contact:

Name ______________________________ Work Phone (___________)_______-_______

Name ______________________________ Work Phone (___________)_______-_______

How did you hear about our practice?______________________________

By signing below, I certify that the above information is accurate to the best of my knowledge. I verify that all information has been filled out in its entirety. Changes to the above information will be made immediately. This information will be updated one year from the date noted below.

Signature ______________________________ Date ________________

Print Name ____

Relationship to patient ____

What pharmacy are you currently using? ______________________________

Penguin Pediatrics PLLC

INSURANCE INFRMATION

Responsible Party ____

Relationship to patient: Mother Father Guardian (Check one)

Primary Insurance Name ____

Subscriber/Policy Holder Name ____

ID # ____

Group # ____

Insurance Address ____

City _______________________________ State ____________________ Zip _______________

Secondary Insurance Name ____

Subscriber/Policy Holder Name ____

ID # ____

Group # ____

Insurance Address ____

City _______________________________ State ____________________ Zip _______________

AUTHORIZATION PAY BENEFITS OF PHYSICIAN:

I certify that I, and/or my dependents have insurance coverage with ____________________(insurance name) and assign directly to Penguin Pediatrics PLLC all insurance benefits, if any otherwise payable to me for services rendered. I hereby authorize the undersigned physician to release and medical information necessary to process these claims. I authorize the use of my signature on all insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. I hereby authorize payments directly to Penguin pediatrics PLLC. I understand that I am financially responsible for the charges not covered nu this authorization or charges not covered by my insurance carrier/third party payers. This consent is valid until the patient is under care of Penguin Pediatrics.

Signature ____ Date _________________________

Print Name ____

Relationship to patient ____

Penguin Pediatrics PLLC

CONSENT FOR MEDICAL CARE

Patient's Name ____

Date of Birth __________/__________/__________

MM DD YEAR

The following person(s) have permission to authorize medical treatment if I am not available to give my consent. I understand that it is the parent/guardian's responsibility to notify Penguin Pediatrics PLLC of any changes to this list of authorized caregivers in writing.

1. Name ____________________ Relationship ____________________
   Home Address ____
   City ____________________ State ______________ Zip ________

2. Name ____________________ Relationship ____________________
   Home Address ____
   City ____________________ State ______________ Zip ________

3. Name ____________________ Relationship ____________________
   Home Address ____
   City ____________________ State ______________ Zip ________

4. Name ____________________ Relationship ____________________
   Home Address ____
   City ____________________ State ______________ Zip ________

Signature ______________________________ Date ____________________

Print Name ____

Relationship to patient ______________________________________

Penguin Pediatrics PLLC

AUTHORIZATION TO DISCUSS TEST RESULTS

Patient's Name ____

Date of Birth ___________/___________/___________

MM DD YEAR

Parent/Legal Guardian Name ____

Home Address ____

City ______________________ State ______________ Zip ___________

Purpose of Request: I authorize Penguin Pediatrics to provide the protected health information of the child mentioned above in this form to the personal representative. As my representative, Penguin Pediatrics can discuss requested information mentioned below about my child/children's health information.

I understand it is my responsibility to have the ordered tests done and have been explained the importance and reasoning for the testing. This agreement remains in full effect until rescinded in writing by parent/legal guardian.

Please circle the health information you would like to give the authorization to be discussed with designated

- I authorize the practice to disclose all of my child/children's protected health information to my
- Normal (Blood, X-Rays, M-Rays, Prescriptions) Tests
- Abnormal (Blood, X-Rays, M-Rays, Prescriptions) Tests
- Both Abnormal and Normal Tests
- School related concerns

The following person(s) listed below are authorized to bring my child (ren):

1. Name ____________________________ Relationship ______________
2. Name ____________________________ Relationship ______________

By signing this agreement I acknowledge it is my responsibility to inform Penguin Pediatrics PLLC of any change in information.

Signature ____________________________ Date ________________

Print Name ____

Relationship to patient ______________________________________