Hartman
PEDIATRICS

Child's Full Legal Name	Preferred Name	DOB	Sex (circle one)
			M / F
			M / F
			M / F
			M / F

Address: _____ City: _____

Primary Phone: _____ Secondary Phone: _____

May we leave detailed voicemails on your primary phone # including test results? Yes / No

E-mail address for patient portal: _____

Preferred method of communication (circle one): e-mail primary phone

Pharmacy Name/location: _____

Parent/Legal Guardian #1:

Name: _____ DOB: ___/___/___ SS#: _____

Work Phone: _____ Employer: _____

Lives with patient? Yes / No If no, please provide address

Parent/Legal Guardian #2:

Name: _____ DOB: ___/___/___ SS#: _____

Work Phone: _____ Employer: _____

Lives with patient? Yes / No If no, please provide address

Insurance: Primary policy: _____ Policy Holder: _____

Secondary insurance: _____ Policy Holder: _____

Emergency Contact: Name/Relationship: _____ Phone: _____
(other than parents)

Besides parents listed above, I give permission to the following people to bring my child to the office and receive medical care:

_____

By signing below, I verify that the above information is accurate. I also acknowledge that I have reviewed the privacy and financial policies set forth by Hartman Pediatrics, that I was offered a copy of these policies and that I and agree to the terms. I authorize Hartman Pediatrics to share information with my child's insurance company for the purpose of processing claims, and I acknowledge that any amount not covered by my insurance is my responsibility and will be paid within 30 days to avoid late fees.

Parent/guardian signature: _____ Date: _____