# Patient Information Sheet

Mother's Full Name _____ Father's Full Name _____

Date of Birth ____/____/____ Soc. Sec # _____ Date of Birth ____/____/____ Soc. Sec # _____

Address _____ Address _____
Street Street

_____ _____ _____ _____ _____ _____
City State Zip City State Zip

Home Phone _____ - _____ - _____ Home Phone _____ - _____ - _____

Cell Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Employer_____ Employer _____

Work Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

Email Address _____ Email Address _____

**CHILDREN:** **(**Please list **ALL** children who are **current patients** including **newborns** and **all new patients**.**)**

_____ Date of Birth _____/_____/_____ S.S # _____ Sex _____
(First, Middle, Last Names)

_____ Date of Birth _____/_____/_____ S.S # _____ Sex _____
(First, Middle, Last Names)

_____ Date of Birth _____/_____/_____ S.S # _____ Sex _____
(First, Middle, Last Names)

_____ Date of Birth _____/_____/_____ S.S # _____ Sex _____
(First, Middle, Last Names)

_____ Date of Birth _____/_____/_____ S.S # _____ Sex _____
(First, Middle, Last Names)

_____ Date of Birth _____/_____/_____ S.S # _____ Sex _____
(First, Middle, Last Names)

Patient lives with? _____

Emergency Contact (Other than parents) _____

Emergency Contact # _____ - _____ - _____ Relationship to patient _____

Primary Insurance _____ Secondary Insurance _____
WE NEED COPY OF INSURANCE CARD WE NEED COPY OF INSURANCE CARD

Person financially Responsible for bill _____ Relationship _____

Address if different _____ _____ _____ _____
Street City State Zip

I, the undersigned, give my consent to treat. I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify the information contained herein is correct. I understand that Highland Pediatrics may not be contracted with all insurance plans. I will be responsible for any amount not paid by insurance.

I understand that Highland Pediatric physicians are not TennCare or Medicaid providers, therefore, Highland Pediatrics cannot file TennCare or Medicaid. I will be responsible for all charges incurred while covered by TennCare or Medicaid.

I agree to pay any collection fees if legal action is necessary in the collection effort of this account.

_____ _____ Date _____
Signature Relationship to Patient

**PATIENT'S NAME**_____ **ACCT #**_____ **DR** _____



*(Please See Reverse Side)*

**COMMUNICATIONS CONSENT:**

By providing my cell, land-line, or any other number(s), I expressly consent to receiving communications from the Provider, its staff, its contractors, collection agents, and other, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, prerecorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers are not a condition of receiving healthcare services.

**Accept** ☐

**Decline** ☐

_____ _____

*Signature of Parent, Legal Representative, or Legal Guardian* *Date*

**PHOTO CONSENT:**

By checking a response below, I consent to allowing Highland Pediatric posting pictures/photos of my child/children in the office that I have mailed or given to the physicians or staff.

**Accept** ☐

**Decline** ☐

_____ _____

*Signature of Parent, Legal Representative, or Legal Guardian* *Date*