PATIENT INFORMATION FORM

Account #: ____________________

Please list all children in the family.

Name: ___________________________ ☐ M ☐ F DOB:____/____/____ Name: ___________________________ ☐ M ☐ F DOB:____/____/____

Name: ___________________________ ☐ M ☐ F DOB:____/____/____ Name: ___________________________ ☐ M ☐ F DOB:____/____/____

Name: ___________________________ ☐ M ☐ F DOB:____/____/____ Name: ___________________________ ☐ M ☐ F DOB:____/____/____

Home Address: ____
Street City State Zip

PRIMARY: (_____)______-_______ Secondary: (_____)______-_______ Email: ______________________________

EMERGENCY CONTACT: ____ Phone: (_______)________-__________
Name

I authorize Beach Pediatrics to leave messages or send text messages at the primary number listed above regarding my child's health information, appointments, test results, and billing unless otherwise specified. ☐ Yes ☐ No

I authorize Beach Pediatrics to email me at the email address listed above regarding my child's health information, appointments, and test results unless otherwise specified. ☐ Yes ☐ No

Please select all that apply *(optional)*: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ Asian

Please circle one. **Mother / Father / Guardian**

Name: ______________________________________

DOB: ______/______/________ SSN: _______-_____-________

Cell: (_____)_______-________ Work: (_____)_______-_______

Occupation: _______________ Employer: _________________

Please circle one. **Mother / Father / Guardian**

Name: ______________________________________

DOB: ______/______/________ SSN: _______-_____-________

Cell: (_____)_______-________ Work: (_____)_______-_______

Occupation: _______________ Employer: _________________

Parents of the child/children are: ☐ Single ☐ Married ☐ Divorced ☐ Separated
If the parents are divorced or separated, what are the legal custody arrangements for the child/children? ☐ Sole ☐ Joint
If sole legal custody, please provide legal documentation to be scanned into patient(s)'s chart.

CAREGIVER AUTHORIZATION — I, the parent/guardian, give authorization to the following relatives and/or caregivers to bring my child/children in for sick visits, testing and/or treatment which is recommended and provided by the physicians and staff of Beach Pediatrics. **This Authorization will remain in effect until further written notice.**

Name/Relationship:_________________________________ Name/Relationship:_________________________________

PRIMARY INSURANCE INFORMATION

Insurance Name: ______________________________

Name of Subscriber: ___________________________

ID#: _______________________________________

Group #:____________________________________

SECONDARY INSURANCE INFORMATION

Insurance Name: ______________________________

Name of Subscriber: ___________________________

ID#: _______________________________________

Group #:____________________________________

PHARMACY

Name: _________________________ Location/Zip:____________________________ Phone: (______) _______-_________

I declare the information I provided above is correct, and if there are any changes, I will notify Beach Pediatrics.

Parent/Guardian Signature: ____ Date: _______/_______/_________

Beach Pediatrics
Office Policies

Please initial each line to indicate that you understand and agree. If you have any questions, don't hesitate to ask us.

______ **Insurance Coverage Terms:** Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your coverage details. We will attempt to verify eligibility and benefits as a courtesy, but we cannot obtain exact payment details until the claim is processed.

______ **Insurance Updates:** You are responsible for providing updated insurance information. If charges are denied due to outdated insurance information, the guarantor will be responsible for any unpaid balances.

______ **Billing Policy:** We bill your insurance at the time of service. After receiving payment or an explanation of benefits (EOB), any remaining balance will be billed to you monthly.

______ **Co-Payments, Deductibles, Co-Insurance:** All applicable copays, coinsurance, and deductible amounts are due at the time of service. These are estimated based on your plan. Any remaining balance will be billed to the guarantor.

______ **No Shows and Cancellations:** Please cancel at least 24 hours before your appointment. A $50 fee applies for missed or late cancelled appointments.

______ **Late Arrivals:** Arriving more than 15 minutes late may require rescheduling, though we will do our best to accommodate you.

______ **Copy of Medical Records:** A $25 fee and written request must be submitted. Please allow two weeks for processing.

______ **Authorization to Treat Minors:** We require parent/guardian consent to treat minors. If someone else brings your child, written authorization is needed.

Acknowledgement & Consent

I have read and understand the office policies and accept financial responsibility for any charges for services provided.

I have received and understand the Notice of Privacy Practices. I agree that my child's health information may be used or shared as needed for care, billing, or clinic operations.

Parent/Guardian Signature: ______________________________ Date: ______________

Printed Name: ____

Child's Full Name ______________________________ DOB: ______________

Child's Full Name ______________________________ DOB: ______________

New Patient Intake Form

Patient Information

Child's Name: ______________________ DOB: __________ Gender: ☐ M ☐ F

Pregnancy & Birth History

Mother's Name: ______________________ Mother's age at birth: ________

Father's Name: ______________________ Father's age at birth: ________

Pregnancy complications: ☐ Yes ☐ No If yes, please describe: ________________

Delivery type: ☐ Vaginal ☐ C-section, reason: ________________

Birth weight: ________ Birth length: ________ ☐ Full-term ☐ Preterm # weeks: ______

Problems immediately after birth (check all that apply):

☐ Jaundice ☐NICU stay ☐Infection ☐Feeding problems Other: ____________

Medical History

Current medications (include supplements): ________________________

Allergies (medications, foods, environment): ________________________

Past problems, hospitalizations, surgeries, or serious illnesses (with dates): ____________

____

Developmental History

Delayed Milestones: ☐ Yes ☐ No If yes, please describe: ________________

Any developmental concerns? ☐ Yes ☐ No If yes, explain:________________

Family Medical History

(Mark for each relative if present — condition — age if alive or age at death)

Relative	Condition(s)	Age
Mother	______________________	______________
Father	______________________	______________
Sibling(s)	______________________	______________
Grandparents	______________________	______________

Social History & Environment

Primary caregiver(s): ________________________________

Daycare/School attendance: ☐ Yes ☐ No If yes, name or setting: ____________

Smoking exposure? ☐ Yes ☐ No Pets at home? ☐ Yes ☐ No If yes, specify: ______

Completed by: ________________________ **Date:** ____________

Physician Signature: ____________________ **Date:** ____________