ALL My KidS PEDIATRICS

PATIENT UPDATE INFORMATION

Patient Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #
Street Address *(no PO Boxes)*		Apt #	Home Phone
City	State	Zip Code	Email *(required for patient portal)*

SIBLINGS WITH SAME RESPONSIBLE PARTY

Name, Birth Date	Name, Birth Date	Name, Birth Date

EMERGENCY CONTACT INFORMATION

Name	Home Phone		Cell Phone	
Address	City	State	Zip	Relationship to patient

INSURANCE INFORMATION

Changed since last visit? ☐ **No** ☐ **Yes, Please fill out below:**

Insurance Name	Insurance Phone	Emdeon # *(if available)*
PolicyHolder Name (*If Medicaid write Self*)	PolicyHolder Relationship to Patient (*Please Circle*) Parent / Self / Other:_____	Healthy Kids Program? *Yes* *No*
ID#/Policy #	Group#	Insurance Address

Who *if* anyone other than parents or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in to All My Kids Pediatrics without your presence and making medical decisions for his or her treatment.	☐ **N/A**	☐ **Yes the following individuals:**

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

I certify that the above information is correct to the best of my knowledge. I release All My Kids Pediatrics, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records.

Patient/Legal Guardian Signature: _____ **Date:** _____

Staff Initial:_____ Date:_____