BURLINGTON PEDIATRICS
MEBANE PEDIATRICS
INFORMATION SHEET

	First Child ⇩	Second Child ⇩	Third Child ⇩
First Name			
Middle Name			
Last Name			
Sex	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female
Birth Date	___/___/___	___/___/___	___/___/___
Patient's Address	______ ______ County: ______	______ ______ County: ______	______ ______ County: ______
Primary Language Spoken	___ English ___ Spanish List other: ______	___ English ___ Spanish List other: ______	___ English ___ Spanish List other: ______
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined to Specify	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined to Specify	___ Not Hispanic ___ Hispanic ___ Unknown ___ Declined to Specify
Race (Check all that apply)	___ Native American ___ White ___ Pacific Islander ___ Black ___ Declined to Specify ___ Asian	___ Native American ___ White ___ Pacific Islander ___ Black ___ Declined to Specify ___ Asian	___ Native American ___ White ___ Pacific Islander ___ Black ___ Declined to Specify ___ Asian
Name of Primary Care Physician			
Insurance Information	Primary Insurance ______ Subscriber's Name: ______ Birth Date: ___/___/___ ID #: ______ Group ID#: ______ Relationship to patient: ______ Secondary Insurance ______ Subscriber's Name: ______ Birth Date: ___/___/___ ID #: ______ Group ID#: ______ Relationship to patient: ______	Primary Insurance ______ Subscriber's Name: ______ Birth Date: ___/___/___ ID #: ______ Group ID#: ______ Relationship to patient: ______ Secondary Insurance ______ Subscriber's Name: ______ Birth Date: ___/___/___ ID #: ______ Group ID#: ______ Relationship to patient: ______	Primary Insurance ______ Subscriber's Name: ______ Birth Date: ___/___/___ ID #: ______ Group ID#: ______ Relationship to patient: ______ Secondary Insurance ______ Subscriber's Name: ______ Birth Date: ___/___/___ ID #: ______ Group ID#: ______ Relationship to patient: ______
Primary Contact Person for Family will be the person receiving the notifications. (If you are 18 years of age or older, list yourself as the Primary Contact.) **If the address is the same as the patient's address, write same.**	Check One: ___ Mother ___ Foster-Mother ___ Self ___ Father ___ Foster-Father ___ Step-Mother ___ Legal Guardian ___ Step-Father ___ Other Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Home Phone: ______ Cell Phone: ______ Work Phone: ______ Email: ______ Birth Date: ______ Name of Employer: ______ SS #: ______ Do you live w/patient? ___ Yes ___ No Who has primary physical custody? (if applicable) ______	Check One: ___ Mother ___ Foster-Mother ___ Self ___ Father ___ Foster-Father ___ Step-Mother ___ Legal Guardian ___ Step-Father ___ Other Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Home Phone: ______ Cell Phone: ______ Work Phone: ______ Email: ______ Birth Date: ______ Name of Employer: ______ SS #: ______ Do you live w/patient? ___ Yes ___ No Who has primary physical custody? (if applicable) ______	Check One: ___ Mother ___ Foster-Mother ___ Self ___ Father ___ Foster-Father ___ Step-Mother ___ Legal Guardian ___ Step-Father ___ Other Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Home Phone: ______ Cell Phone: ______ Work Phone: ______ Email: ______ Birth Date: ______ Name of Employer: ______ SS #: ______ Do you live w/patient? ___ Yes ___ No Who has primary physical custody? (if applicable) ______

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Secondary Contact Person for Family (If you are 18 years of age or older, list yourself as the Primary Contact.)

If the address is the same as the patient's address, write same.

Check One: ___ Mother ___ Foster-Mother ___ Father ___ Foster-Father ___ Step-Mother ___ Legal Guardian ___ Step-Father ___ Other	Check One: ___ Mother ___ Foster-Mother ___ Father ___ Foster-Father ___ Step-Mother ___ Legal Guardian ___ Step-Father ___ Other	Check One: ___ Mother ___ Foster-Mother ___ Father ___ Foster-Father ___ Step-Mother ___ Legal Guardian ___ Step-Father ___ Other
Name:	Name:	Name:
Address:	Address:	Address:
City: State:	City: State:	City: State:
Zip:	Zip:	Zip:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email:	Email:	Email:
Birth Date:	Birth Date:	Birth Date:
Name of Employer:	Name of Employer:	Name of Employer:
SS #:	SS #:	SS #:
Do you live w/patient? ___ Yes ___ No	Do you live w/patient? ___ Yes ___ No	Do you live w/patient? ___ Yes ___ No
Who has primary physical custody? (if applicable)	Who has primary physical custody? (if applicable)	Who has primary physical custody? (if applicable)

Emergency Contact: **Relationship:**

Phone: **Preferred Language to speak:**

Please circle (ONLY ONE) preferred method of contact for each item listed below:

Recalls:	No Contact	Home Phone	Cell Phone	Text to Cell	Home Email
General Notices:	No Contact	Home Phone	Cell Phone	Text to Cell	Home Email
Patient Portal:	No Contact	Text to Cell	Home Email		
Reminders:	No Contact	Home Phone	Cell Phone	Text to Cell	Home Email

To obtain accurate family medical history, if contacts listed on the previous page are NOT the biological parents, list both biological parents (if known and fill in any and all information)

If this section doesn't apply, list N/A.

Biological Mother:	Biological Mother:	Biological Mother:
Birth Date:	Birth Date:	Birth Date:
Biological Father:	Biological Father:	Biological Father:
Birth Date:	Birth Date:	Birth Date:

(Biological parents have parental rights unless they have been taken away by a court order. Parental rights are different than custody orders. If either biological parent listed above has NO parental rights per a SIGNED COURT ORDER, a copy of that COURT ORDER is required to be on file in our office. If a child has been adopted, a copy of the adoption court order is also required to be on file in our office.)

FINANCIAL GUARANTOR
This is the person that will receive Billing Statements. Parents must agree on this and work arrangements out among themselves for payment issues.

Printed Name:	Printed Name:	Printed Name:
Relationship to patient:	Relationship to patient:	Relationship to patient:
Address:	Address:	Address:
City: St: Zip:	City: St: Zip:	City: St: Zip:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Birth Date:	Birth Date:	Birth Date:
Name of Employer:	Name of Employer:	Name of Employer:
SS#:	SS#:	SS#:

Names of other family members that are our patients:

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

I authorize the release of protected health information to any consultant for the purpose of continuing care. I authorize the release of information acquired in the course of my child's examination for the purpose of filing insurance claims. I assign insurance payment directly to Burlington Pediatrics. I understand that I am ultimately responsible for payment of charges, whether or not they are covered by insurance. This authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be as valid as the original.

Date _____ Signature _____

Relationship to Patient _____