

Pediatric Care, Inc.

8250 Winton Road Suite 103, Cincinnati, Ohio 45231
8752 Union Centre Blvd. West Chester, Ohio 45069

Names of Children

(Please Print)

Date _____

Last Name	First Name	Middle	Sex M/F	Date of Birth	Any Known Allergies Please Describe

(Please list additional children on the back)

Patient Address _____ **City** _____ **ST** _____ **Zip** _____

Home Phone Number () _____

Emergency Contact Other Than Parents: _____

Relationship of Emergency Contact _____ **Phone Number**() _____

Name of Additional Caretaker _____ **Relationship** _____ **Phone Number**() _____

(Example: stepparent, grandparent, babysitter, etc.)

Responsible Party Information

Father/Legal Guardian

Mother/Legal Guardian

Name	SSN	Name	SSN		
Birthdate		Birthdate			
Address		Address			
City	ST	Zip	City	ST	Zip
Home Phone ()		Home Phone ()			
Cell Phone ()		Cell Phone ()			
Employed By		Employed By			
Occupation		Occupation			
Work Phone ()		Work Phone ()			
Email Address		Email Address			

Insurance Information

(Please furnish us with a copy of your insurance card.)

NOTE: Patients who carry health insurance should remember that payment for our services is the responsibility of the insured, and patients are expected to pay their co-pay at the time of service. Any balance not covered by insurance is due and payable upon receipt of billing statement.

Primary Insurance		Secondary Insurance	
Name of Insured		Name of Insured	
Relationship to Patient		Relationship to Patient	
ID #	Group#	ID #	Group#

ACKNOWLEDGEMENT OF RECEIPT: I hereby acknowledge that I have received the Notice of Privacy Practices of Pediatric Care, Inc. I understand this notice contains information regarding how Pediatric Care, Inc. uses my medical information.

ASSIGNMENT AND RELEASE: I hereby authorize Pediatric Care, Inc., to treat and to furnish information to insurance carriers concerning treatment, and I hereby assign to the provider all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also authorize Pediatric Care, Inc. to make reasonable disclosures of my children's Personal Health Information to parents, schools, doctors, and others involved in their care, unless otherwise specified.

Parent's Signature: _____ Date _____