Pediatric Care, Inc.
800 Compton Road, Suite 25 Cincinnati, Ohio 45231
8752 Union Centre Blvd. West Chester, Ohio 45069
www.pediatriccareinc.com

Names of Children **(Please Print)** **Date**_____

Last Name	First Name	Middle	Sex M/F	Date of Birth MM/DD/YYYY	Primary Language	Race	Ethnicity H = Hispanic or Latino N = Not Hispanic or Latino D = Decline

(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 of Emergency Contact ( )**_____

What School District does your child currently attend? _____

What is your preferred method of contact? Email, Cell Phone, Home Phone or Text ? *Please Circle*

For office alerts preferred Email_____**Preferred Cell Phone ( )** _____

Preferred Pharmacy Name & Location _____ **Pharmacy Phone ( )** _____

How did you hear about our office?_____

Which provider do you prefer to see at Pediatric Care, Inc.? *Please Circle*

Dr. Delsignore **Dr. Hein** **Dr. Partusch** **Dr. Strasser** **Peg Hallman, NP** **Amy Valerius, NP**

Contact Information

Father/Legal Guardian	Mother/Legal Guardian
Name	Name
Birthdate SSN	Birthdate SSN
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

Name of Person Responsible for Bill_____

Billing Address (if different than above)_____

City_____**State**_____**Zip**_____**Billing Phone ( )**_____-_____

*****Please Complete The Back Of This Form*****

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**
DOB:	**DOB:**
Relationship to Patient	**Relationship to Patient**
ID # **Group#**	**ID #** **Group#**

Please read and **initial** each line. If you have questions, please ask the front desk for assistance.

1. _____ In the event that the parent(s)/legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize the physicians at Pediatric Care, Inc. to evaluate and treat any and all conditions that require immediate attention.

2. _____ 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.

3. _____ FINANCIAL POLICY: I have received a copy of Pediatric Care, Inc.'s Financial Policy and understand and agree to the conditions outlined in the policy.

4. _____ FAILED AND CANCELLED APPOINTMENT POLICY**:** I understand the office requires 24 hour in advance notification if I am unable to keep or need to reschedule an appointment. Failure to provide sufficient notice may result in a **missed appointment fee** of up to **$50.00** per patient.

ASSIGNMENT AND RELEASE: I hereby authorize Pediatric Care, Inc., to treat and furnish information to insurance carriers concerning treatment. 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. Additionally, Pediatric Care, Inc. has my permission 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_____