**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 or live in?** ____________________________________________________

**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    Kristen Curington, NP    Amy Valerius, NP**

| Father/Legal Guardian/Responsible Party | Mother/Legal Guardian/Responsible Party |
|---|---|
| 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 |

## ***Insurance Information***

## (Please complete and 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. ______ Pediatric Care ultimately holds both parents responsible for payment unless court documents are provided stating otherwise. In circumstances where the parents are separated or divorced, Pediatric Care will not act as a mediator in collecting our payments.

5. ______ 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.

I agree to allow Pediatric Care, Inc. to send me automated text messages to the number I have provided for appointment and scheduling reminders, appointment cancellations, office closures etc.

Parent's Signature:________________________________________ Date____________________