New Patient Pack

Child's Information

Child's Name _____ □ Male □ Female
(First) (Middle) (Last)

Name Preferred _____ Child's DOB _____ Child's SS _____

Child's Street Address _____

Child's Mailing Address _____

City _____ State _____ Zip _____ Home # _____

Race: ____ Asian, ____ Black/African American, ____ Caucasian, ____ Hispanic, _____Other

With whom does child live with? □ Mom and Dad □Mom □Dad □Other
Who has legal custody? □ Mom and Dad □Mom □Dad □Other
Who is responsible party? □ Mom and Dad □Mom □Dad □Other

Emergency Contact & Relationship (Someone Not in Home)

1. Name _____ Phone # _____
2. Name _____ Phone # _____

Parent's Information

Mother's Information

Name: _____
Maiden Name: _____
DOB _____ SS# _____
Address _____
City _____
State _____ Zip _____
Home # _____ Cell # _____
Employer _____
Employer Address _____
Work # _____

Father's Information

Name: _____
DOB _____ SS# _____
Address _____
City _____
State _____ Zip _____
Home # _____ Cell # _____
Employer _____
Employer Address _____
Work # _____

Parent or Guardian Email Address for access to our patient information portal

Email Address:_____

How did you hear about us?_____

For appointment reminders by text please put in cell number you would like your reminder sent to_____

INSURANCE INFORMATION

Primary Insurance Name: _____
Effective Date: _____
Telephone Number:_____
ID Number: _____Group Number: _____
Full Name of Insured: _____
Co-Pay Amount: _____

PHARMACY INFORMATION

Preferred Pharmacy _____
Location _____ Phone No. _____

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Zoe Pediatrics to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Zoe Pediatrics. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

CHILD'S PREVIOUS PEDIATRICIAN

Name _____ Phone # _____

MEDICATIONS

Is you child taking any medication on a regular basis? □ Yes □ No
Please specify _____

Authorization for Treatment

I (We) _____authorize Zoe Pediatrics and its
Print Name of Legal Guardian(s)

personnel to deliver medical services to my child, _____.
Child's Name and Date of Birth

I (We) authorize the following people to bring my child in for treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Legal Guardian Date

Relationship to patient: _____

Permission for Telephone Messages

Patient confidentiality is a top priority at Zoe Pediatrics. Therefore, it is important that parents or patients over 18 years of age provide us with the following information to ensure there is no violation of your or your child's privacy.

Please name all persons and places where we may leave health information including return phone messages, lab and test results, and scheduling:

Name: _____
Email address:_____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Name: _____
Email address:_____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Parent signature: _____ Date: _____

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Zoe Pediatrics Privacy Officer at **706-938-0990**; by submitting a written request to **210 Hannahs Mill Rd Thomaston, GA 30286**.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name _____

Signature of Patient/Personal Representative _____

Date _____