BARRINGTON PEDIATRIC ASSOCIATES, INC

PATIENTS NAME: **DOB:**

ADDRESS: **CITY:** **STATE**: **ZIP**:

HOME PHONE: **ALT/CELL:**

★EMAIL★(It is necessary for patient portal): _____

*** ENROLL FOR ACCESS TO PATIENT PORTAL?: (please circle one) YES / NO**

*** CONFIRMATION CALLS: (please check one) Phone call _____ OR Text message _____**

***PATIENT RACE (please circle): American Indian/Alaskan Asian Hawaiian White Black/African American Refuse to Report**

***PRIMARY LANGUAGE SPOKEN IN HOME:** _____

***PATIENT ETHNICITY: (please check one) HISPANIC_____ OR NON-HISPANIC_____ OR Refuse to Report_____**

PHARMACY NAME, LOCATION AND PHONE #: _____

PARENT/GUARDIAN INFORMATION-1

RELATION TO PATIENT: _____

NAME: _____

DOB: _____

MOM'S SS# (MEDICAID MEMBERS ONLY): _____

ADDRESS: _____

PARENT/GUARDIAN INFORMATION-2

RELATION TO PATIENT: _____

NAME: _____

DOB: _____

ADDRESS: _____

PRIMARY INSURANCE:

COPAY: $

POLICY NUMBER:

CARDHOLDER NAME:

CARDHOLDER'S DOB:

SECONDARY INSURANCE (IF ANY):

POLICY NUMBER:

CARDHOLDHERS NAME:

CARDHOLDER'S DOB:

PREVIOUS PHYSICIAN: _____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO BARRINGTON PEDIATRIC ASSOCIATES, INC FOR ANY SERVICES RENDERED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF BARRINGTON PEDIATRIC'S HIPAA COMPLIANCE AND FINANCIAL POLICY.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

_____ **DATE** _____