# JONESBORO PEDIATRICS

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Welcome to Jonesboro Pediatrics! Please complete the following information completely so we can best serve you. All information will be strictly confidential. Please also provide the front desk with your picture ID and insurance card.

## PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Sex: Male Female Primary Language: _____ Social Security Number: _____

Address: _____

Home Phone:_____ Cell Phone: _____

Race (Circle One): Black/African American White Asian Hispanic Native Hawaiian Other No Response

Ethnicity (Circle One): Hispanic Non-Hispanic E-mail Address: _____

Please Note: By providing an email address and/or cell phone, you consent Jonesboro Pediatrics, LLC to email or text on behalf of the patient with office related communications which may contain protected medical information regarding the patient. Initials _____

Reason for Visit: _____ Emergency Contact Name: _____

Emergency Contact Phone: _____ Relation to Patient: _____

## RESPONSIBLE PARTY

Name: _____ Relation to Patient: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Occupation: _____

Employer Address: _____

Employer Phone: _____ Driver's License Number and State: _____

Please Continue on the Back

## INSURANCE

Primary Insurance Company: _____ ID Number: _____

Medicaid Policy? Yes No Effective Date: _____ Group Number: _____

Insurance Phone Number: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Insurance through Employer? Yes No

Secondary Insurance Company: _____ ID Number: _____

Medicaid Policy? Yes No Effective Date: _____ Group Number: _____

Insurance Phone Number: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Insurance through Employer? Yes No

## MEDICAID SIGNATURE ON FILE

I request the payment of authorized Medicaid benefits be made on my behalf to Jonesboro Pediatrics, LLC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.

_____ _____

Patient, Parent or Guardian Signature (if patient is under 18 years of age) Date

## PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Jonesboro Pediatrics for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for medical benefits.

_____ _____

Patient, Parent or Guardian Signature (if patient is under 18 years of age) Date

## CONSENT TO TREAT

By signing our consent to treat, you are authorizing the physicians and personnel of Jonesboro Pediatrics to conduct physical examinations and routine services, order and perform tests and administer treatment deemed necessary by the examining provider. Should treatment be performed, the medical provider or clinical staff will fully inform you as to the nature of the procedure, the alternatives to treatment and the risks involved. You will be given the opportunity to ask questions and have your questions answered.

_____ _____

Patient, Parent or Guardian Signature (if patient is under 18 years of age) Date