Family Data Sheet

PANORAMA PEDIATRIC GROUP

Patient Name:_____ Date of Birth:_____

Patient Phone # (if older than 12 yo and applicable): _____ Email address: _____

General Information

Race/Ethnicity: White or Caucasian Black or African American Hispanic

Asian / Pacific Islander American Indian or Alaskan Native Other:_____ Prefer not to say

Primary Language: English Other:_____

Lives with *(please specify)):* Parent(s) _____ Guardian *(Provide legal paperwork)*:_____

Contact Information

Primary Contact: _____ Relationship to patient:_____ Phone:_____

Secondary:_____ Relationship to patient:_____ Phone:_____

Parent Name:_____ Parent Name:_____

Email: _____ Email:_____

Address:_____ Address:_____

Zip:_____ Date of Birth:_____ Zip:_____ Date of Birth:_____

Cell #:_____ Other #:_____ Cell #:_____ Other #: _____

Employer:_____ Work #:_____ Employer:_____ Work #:_____

Maiden Name:_____

Other Parent Name:_____ Other Parent Name:_____

Relationship: _____ Relationship:_____

Email:_____ Email:_____

Address:_____ Address:_____

Zip:_____ Date of Birth:_____ Zip:_____ Date of Birth:_____

Cell #:_____ Other #:_____ Cell #:_____ Other #: _____

Employer:_____ Work #:_____ Employer:_____ Work #:_____

(If Guardian) Name:_____ Relationship:_____ Phone #_____

Address: Zip:

Insurance Information

Primary Insurance Information (if parents are divorced/not married, who has legal responsibility for the health insurance coverage for the child? Provide appropriate legal paperwork)

Insurance Co:_____ Subscriber Name: _____ DOB:_____

Subscriber ID: Phone #:

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HIPAA & Privacy Information		
Can we contact you at the following? Check box if yes, leave blank if no	**Appointment Info**	**Medical Info**
Leave message on home phone?		
Leave message on cell phone?		
Send text message?		
Leave a message on work phone? Extension? _____		
Leave message with another person?		
Send information via regular mail?		
Send information via e-mail/ portal?		

List anyone else we are allowed to contact and circle yes or no if you authorize the following:

Name (First & last)	**Relationship**	**Phone # (s)**	**Contact method (circle all that apply)**		
			Schedule & attend appt's?	Yes	No
			Receive and provide disclosure of medical & financial info?	Yes	No
			Make medical decisions?	Yes	No
			Can be used as an emergency contact?	Yes	No
			Schedule & attend appt's?	Yes	No
			Receive and provide disclosure of medical & financial info?	Yes	No
			Make medical decisions?	Yes	No
			Can be used as an emergency contact?	Yes	No

Acknowledgement and Authorization

By signing below, I hereby acknowledge all the above information is true and accurate. I also agree to update Panorama Pediatric Group when any information has changed. I acknowledge that Panorama Pediatric Group will use any / all phone numbers listed to contact me regarding account balances. I authorize the release of information of any medical information necessary to process insurance claims and the release of information back to my physician. I authorize payment of medical benefits to Panorama Pediatric Group and all providers within the practice for services rendered.

Patient / Parent or Legal Guardian Signature (if a minor): _____Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA requirement):

Effective Date: This notice is in effect as of September 23rd, 2013

I acknowledge that I have been offered to review and receive a copy of Panorama Pediatric Group, RLLP's Notice of Privacy Practices:

Patient / Parent or Legal Guardian Signature (if a minor): _____Date: _____

Account Number & Team Member's Initials with date (office use only):_____