18+ CHILDREN'S MEDICAL GROUP, P.C. 18+

PATIENT'S NAME _____ DOB ____/____/____ SEX _____
LAST FIRST MIDDLE

ADDRESS _____
STREET APT # CITY STATE ZIP

EMAIL ADDRESS _____ OCCUPATION _____

CELL PHONE _____ HOME or WORK PHONE _____

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY) _____

EMAIL ADDRESS FOR BILLING STATEMENTS _____

BILLING ADDRESS _____
(IF DIFFERENT THAN ABOVE) STREET APT # CITY STATE ZIP

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

PRIMARY PROVIDER YOU SEE AT CHILDREN'S MEDICAL GROUP _____

PREFERRED PHARMACY _____ PHONE _____

STREET/CITY _____

RACE:
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ HISPANIC
- ☐ OTHER

ETHNICITY: HISPANIC OR LATIN _____ NOT HISPANIC OR LATIN _____

PREFERRED LANGUAGE: _____

AUTHORIZATION TO LEAVE MEDICAL INFORMATION and/or MESSAGE

In accordance with HIPAA Privacy Rule, individuals have the right to request a restriction on uses and disclosures of their protected health information (PHI). We at Children's Medical Group, P.C., must have your authorization as to where we may leave messages. We need to know in writing what phone number(s) we may call to speak with you or with whom we may leave a message. It is our office policy to NOT release confidential and/or unauthorized information by home, cell, or work telephone or by answering machine or voicemail. Whenever returning telephone calls and the answering machine picks up, we will NOT leave a message *if* the name or telephone number is not on the recorded message to identify the residence. We will simply request that you return the call. Information will also NOT be given to any unauthorized person who may answer the telephone.

I authorize Children's Medical Group providers and/or staff to leave medical information pertaining to my care with household members/answering machines/voicemail, by the following methods and will assume responsibility to notify them whenever this information changes. In addition, staff may provide information concerning appointment confirmation, rescheduling, lab results, vaccine information or nurse follow-up calls. **Please provide numbers that we have permission to use and check appropriately for permission you are authorizing.**

Phone # _____

Phone # _____
- O Leave message with appointment, time & date
- O Leave message regarding lab results, vaccines
- O Leave medical info and/or nurse return calls
- O Leave message to call office
- O Do not leave message

Fax Communication to home Yes _____ No _____
Number provided at time of need
Fax Communication to work Yes _____ No _____
Number provided at time of need
Fax Communication to school
Number provided at time of need Yes _____ No _____
Mail to home address on file Yes _____ No _____

Email address for appointment reminders: _____@_____

PLEASE SEE REVERSE SIDE