Lactation Information Sheet

BLOOMINGTON PEDIATRICS

Today's Date: _____

Mother's Birthdate: _____

First Name: _____ **Middle Initial**: ____ **Last Name**: _____

Address: _____ Sex: M____ F____ Transgender ____
House number/Street name City, State, Zip code

Primary Phone: _____ **Cell Phone:** _____ **Other:** _____

Emergency Contact: Last name: _____ First name: _____ Sex: M/F

Do we have permission to contact this person regarding matters of your care? ___ Yes ___ No

Ethnicity (check one):

- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Prefer not to report

Primary race (check all that apply):

- ☐ White
- ☐ African American/Black
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ Asian Indian
- ☐ Native Hawaiian
- ☐ American Indian
- ☐ Other Race
- ☐ Prefer not to report

Preferred language(check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐ Yes ☐ No

Insured Subscriber / Responsible Party Information

Name of Primary Insurance Company: _____ ID# _____ Group# _____

Name of Subscriber on the Insurance Card: _____

Subscriber's address, if different from patient: _____

Subscriber's phone number: _____ Subscriber's Employer: _____

Subscriber's Date of Birth: _____ Subscriber's Relationship to Patient: _____

Same as child: ___ Yes ___ No ***If yes**, Please list child's name* _____

Responsibility for Payment for Services Rendered

By signing below, I authorize Bloomington Pediatrics to submit claims for services rendered to the insurance company/companies listed by me. I authorize the release of protected health information to said insurance companies for the processing of claims. I understand that I am responsible for payment of services rendered and agree to pay any fees for services not covered by insurance, including, but not limited to co-insurance and deductible amounts. I agree to pay at the time of service any co-payment required by my insurance. I also understand I will be held responsible for the payment of any collection fees should my account be sent into collection proceedings.

Signature: _____ **Date**: _____

Consent to Medical Treatment

By signing below, I consent to and authorize the physicians, nurses, and other healthcare providers at Bloomington Pediatrics to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures, and I understand that no one can guarantee how well treatments or procedures will work.

Signature: _____ **Date**: _____