BLOOMINGTON PEDIATRICS

Patient Information Sheet

Today's Date: _____

Patient Information

Patient's Legal Name *(First, Middle, Last)* | **Date of Birth** | **Pediatrician/Provider**

Patient's Preferred Name/Nickname | **Gender at Birth** Female / Male | **Gender Identity/Pronouns** *(if different than gender at birth)*

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Preferred Language | **Interpreter Needed?** ☐ Yes ☐ No

Race
☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Asian Indian ☐ Caucasian/White
☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ ☐ Decline to Answer

Parents / Legal Guardian Information

Primary Parent Name *(First, Middle, Last)* | **Relationship to Patient**

Home Address | **City** | **State** | **Zip**

Email Address | **Enable Portal Access?** ☐ Yes ☐ No | **Phone Number**

Additional Parent Name *(First, Middle, Last)* | **Relationship to Patient**

Home Address | **City** | **State** | **Zip**

Email Address | **Enable Portal Access?** ☐ Yes ☐ No | **Phone Number**

Does the patient live with both biological parents? ☐ Yes ☐ No

If no, what is the patient's current living situation? *(select answer below)*

☐ Single-Parent Custody ☐ Joint Custody ☐ Foster Care ☐ Adoptive Family ☐ Other Legal Guardian(s):

Please provide <u>all</u> court documents for legal guardianship, custody/medical decision making, or any other legal proceedings affecting the patient

Sibling Information

Patient's Legal Name *(First, Middle, Last)*	**Date of Birth**	**Patient's Legal Name** *(First, Middle, Last)*	**Date of Birth**

Insurance Information

Name & Address of Primary Insurance Company		Name of Subscriber on Insurance Card		
Policy ID Number	**Group ID Number**	**Subscriber's Home Address**		
Policy Effective Date	**Subscriber's Birthdate**	**City**	**State**	**Zip**
Subscriber's Employer	**Subscriber's Relation to Patient**	**Subscriber's Phone Number**		

Name & Address of Secondary Insurance Company		Name of Subscriber on Insurance Card		
Policy ID Number	**Group ID Number**	**Subscriber's Home Address**		
Policy Effective Date	**Subscriber's Birthdate**	**City**	**State**	**Zip**
Subscriber's Employer	**Subscriber's Relation to Patient**	**Subscriber's Phone Number**		

Responsibility for Payment of Services Rendered

By signing below, I hereby 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 of Guarantor / Responsible Party	**Date**

Authorization to Release Information

By signing below, I hereby authorize Bloomington Pediatrics to contact me in my preferred method indicated below to send me appointment reminders and other practice information. I also authorize Bloomington Pediatrics to release any information required during my child's care and treatment, including referrals to other medical facilities for specialist care, in response to requests from my insurance company for quality assurance measures, and other appropriate disclosures of protected health information as outlined in Bloomington Pediatrics' Notice of Privacy Practices document. I further acknowledge I have been offered a copy of the Privacy Notice which describes in detail how my child's health information is used and shared in accordance with the US Department of Health & Human Services requirements under the Health Insurance Portability & Accountability Act (HIPAA). I understand I may obtain a current copy at the front desk or by visiting the practice website at www.bloomingtonpediatrics.com.

Signature of Parent/Legal Guardian	**Date**

Name of Preferred Contact for Notifications	**Preferred Method of Contact** ☐ **Phone Call** ☐ **Text** ☐ **Email** *(Enter preferred phone # or email) here:*

You may opt out of notifications at any time by contacting the practice at 309-662-0504, opt 3.

Authorization to Release Information, continued

Preferred Pharmacy Name	Pharmacy Address	State	Zip

Electronic Prescriptions: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this form, you authorize us to do so.

Signature of Parent/Legal Guardian	Date

Immunizations: Our electronic medical record program allows your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this form, you authorize us to submit this data. If you wish to opt out, please advise our front desk receptionist.

Signature of Parent/Legal Guardian	Date

Consent to Medical Treatment

I hereby certify that I am the parent or legal guardian of the patient identified on this form. By signing below, I consent to and authorize the physicians, nurses, and other healthcare providers at Bloomington Pediatrics to provide treatment to my child, including, but not limited to: receiving a history of present illness, receiving disclosures of protected health information, and any and all healthcare examinations, treatment, diagnostic testing medication administration, immunizations or other medical treatment as deemed reasonably medically necessary by their professional judgment. I understand that there are risks with all medical treatments and procedures, and I understand that Bloomington Pediatrics cannot guarantee that any medical treatment will be successful or without complications such as serious illness, injury, or death.

Signature of Parent/Legal Guardian	Date

Authorization for Other Adult Caregivers

By signing below, I hereby authorize, in addition to the legal guardians of the patient, the adult persons listed below may schedule and/or accompany the patient to their appointments, receive any and all protected health information about the patient and consent to the provision of medical care for the patient including, but not limited to: providing a history of present illness, any and all healthcare examinations, diagnostic testing, administration of immunizations, and any other medical treatment deemed reasonably medically necessary by Bloomington Pediatrics. This consent will expire upon the patient's 18th birthday, at which time a new consent must be signed by the patient.

Name of Other Adult Caregiver	Caregiver Relation to Patient	Caregiver Phone Number
Name of Other Adult Caregiver	**Caregiver Relation to Patient**	**Caregiver Phone Number**
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Before the patient's 18th birthday, the above authorization may be revoked or updated by notifying the practice either in person or in writing and a new authorization may be submitted. In situations of parental separation or divorce, legal documentation must be provided to validate single parent authority on medical decision making, or that a parent does not have legal access to the patient record or to make such changes. No action will be taken without court documentation to support the request.

Signature of Parent/Legal Guardian	Date