ASSOCIATED ENDOCRINOLOGISTS

PEDIATRIC DEMOGRAPHIC QUESTIONNAIRE – NEW PATIENT (< age 18)

PATIENT/CHILD INFORMATION (PLEASE PRINT):

Child's Name: _____ Gender: ☐ Male ☐ Female Date of Birth: _____

Child resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

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Mother's (or Guardian's) Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Occupation: _____

****

Father's (or Guardian's) Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Occupation: _____

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Parents' Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

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INSURANCE INFORMATION:

Primary Insurance: _____Member ID: _____ Group #: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Employer: _____ Phone: (_____) _____

Employer Address: _____

Subscriber Date of Birth: ____-____-_____ Secondary coverage with CSHCS? ☐ YES ☐ NO

****

GUARANTOR:

Name: _____ Relationship to patient: _____

Phone: _____ Date of Birth: ____-____-_____ Employer: _____

****

EMERGENCY CONTACT:

Name: _____ Relationship to patient: _____

Cell Phone: _____ Alt Phone: _____

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PREFERRED PHARMACY INFORMATION:

Name: _____ Phone: _____

Address: _____ Fax: _____

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MESSAGES

OK to leave a detailed message at home? ☐ YES ☐ NO OK to leave a detailed message at work? ☐ YES ☐ NO

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CONSENT FOR RELEASE OF INFORMATION:

I give Associated Endocrinologists permission to release my child's information including:

- ☐ Entire medical record
- ☐ Blood Tests
- ☐ X-rays
- ☐ Appointment Details
- ☐ Billing Information

to: Name & relationship to patient: _____)

Name & relationship to patient: _____)

Name & relationship to patient: _____)

Signature:_____ Date: _____

(A signature is required for this consent to be considered valid)

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SIGNED ACKNOWLEDGMENTS, ASSIGNMENTS AND AUTHORIZATIONS:

By signing below:

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I hereby authorize and request my insurance company to pay benefits otherwise payable to me directly to Associated Endocrinologists; I understand that my insurance carrier may pay less than the actual bill for services. I acknowledge and agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

I hereby assign to my provider the right to pursue and receive payment(s) directly.
I hereby assign to my provider the right to pursue all administrative appeals and litigation as necessary.
I hereby assign to my provider the right to pursue other alleged ERISA violations and other causes of action, including but not limited to the right to pursue payment and other ERISA claims.

I certify that I have read and understand the HIPAA Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature _____ **Date** _____

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DOCUMENTATION OF REFUSAL OR INABILITY TO PROVIDE SIGNED ACKNOWLEDGMENTS:

On _____, _____ presented this acknowledgement of receipt
(today's date) *(name of AEG representative)*

and review of "PATIENT NOTICE OF PRIVACY PRACTICES" to _____
(name of patient/parent/guardian)

The patient/parent/guardian refused _____ or was unable to provide _____ a signature when requested.