

ELM STREET PEDIATRICS

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Patient Last Name		First Name	M.I.	Patient Date of Birth
Address: Street				Patient Sex: M F
City	State/Zip			Siblings (Name/DOB):
Home Telephone	Work Telephone	Cell Phone		
Parent who the insurance is under (Full Name, as on the card)				
Address (if different from above)				
Emergency Contact				Telephone

NEW PATIENTS ONLY

Mother/Guardian's Name: _____	Father/Guardian's Name: _____
Occupation: _____	Occupation: _____
Address (if different): _____	Address (if different): _____
City/State/Zip: _____	City/State/Zip: _____
Phone (Primary): _____	Phone (Primary): _____

Child's Medical Information:

(Birth) Weight: _____	Any Neonatal Problems? _____
Length: _____	_____
Apgars: _____	_____

Allergies: _____

History of Illness (Please include dates & any infectious disease, e.g. chickenpox):

Family Health Problems/ History of Disease, especially asthma, allergies, heart disease <50 years old, diabetes, thyroid disease (please indicate family member & age):

**Primary Insurance claims will be filed on your behalf with correct insurance information.
Please supply our office with legible copies of the front & back of your most current insurance card.
Supplementary/Secondary carriers are filed ONLY for Medicare patients.**

ASSIGNMENT & RELEASE:

I hereby consent for Elm Street Pediatrics to provide me with medical treatment. I authorize the release of medical information contained in my chart and/or the insured's insurance company in order to process any bills/claims. I authorize the use and disclosure of my private health information for the purpose of Treatment, Payment and Healthcare Operations. I have received a copy of the Notice of Primary Practices and have been given the opportunity to ask questions about the NPP. I authorize payment by my and/or the insured's insurance company directly to Susan J Nelson, MD, SC (DBA Elm Street Pediatrics). Should my insurance company deny or not cover charges for "ANY" reason, I accept full financial responsibility for the full amount of the bill.

Signature of Parent/Legal Guardian

Today's Date

SIGNATURE IS REQUIRED YEARLY before we can treat the patient · Please ask for a copy of our privacy policy