Bright Future Pediatrics

PATIENT INFORMATION SHEET FOR PATIENTS > 18 Y/O

PATIENT'S FULL NAME **D.O.B./** **RACE/ETH** **SEX** **PREF MD**

_____ _____ _____ ____ Dr. _____

HOME ADDRESS:_____ CITY_____ STATE_____, ZIP_____

HOME PHONE:_____ CELL#: _____

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME_____
DOB_____
SOCIAL SECURITY #_____
ADDRESS_____
HOME PH._____ CELL_____
EMPLOYER_____
WORK PHONE_____

MOTHER'S NAME_____
DOB_____
SOCIAL SECURITY #_____
ADDRESS_____
HOME PH._____ CELL_____
EMPLOYER_____
WORK PHONE_____

PRIMARY INSURANCE
COMPANY_____
EFFECTIVE DATE_____
SUBSCRIBER NAME_____
SUBSCRIBER DOB _____
EMPLOYER_____
GROUP #_____
SUBSCRIBER #_____
RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE
COMPANY_____
EFFECTIVE DATE_____
SUBSCRIBER NAME_____
SUBSCRIBER DOB_____ _____
EMPLOYER_____
GROUP #_____
SUBSCRIBER #_____
RELATIONSHIP TO PATIENT_____

PLEASE PRESENT INSURANCE CARD SO IT CAN BE COPIED

EMERGENCY CONTACT (NOT LIVING WITH YOU)
NAME_____ RELATIONSHIP_____
ADDRESS_____ _____ _____ _____
HOME #._____ CELL #_____ WORK #_____

RELEASE OF INFORMATION

I consent to the use and release of any information, including the diagnosis and the records of any treatment or examination rendered by the medical practice of Bright Future Pediatrics to the above individuals listed who have authority to act on behalf of the patient child (children), insurance companies, governmental payers, healthcare practitioners and other persons/entities for purposes of treatment, payment and business operation of Bright Future Pediatrics.

Please check one:

_____Okay to release medical information to parents _____ Do Not release medical information to parents

Signature:_____ Date:_____

FOR OFFICE USE: UPDATED BY:_____ DATE:_____ UPDATED: 12/21/2023