	First Child	Second Child	Third Child	Fourth Child
First Name				
Middle Initial				
Last Name				
Date of Birth				
Social Security #				
Sex (M/F)				
Primary Language Secondary Lang				
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown
Race (Check all that apply)	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander
Pharmacy Info:	**Name:** **Phone:**	**Name:** **Phone:**	**Name:** **Phone:**	**Name:** **Phone:**

- *Please use another form if space for additional children is needed.*

Address1: _____

Address2: _____

City, State, Zip:_____

Primary Phone: (_____) _____ - _____

Does this address and primary phone apply to all children shown? **Yes** **No** (Circle one. If No, provide necessary information here.)

Insurance Information - Please present card(s) to be scanned at every visit. Co-Pays, Deductibles and Non-Covered services are due at the time of service

Primary Insurance Company:_____Effective Date: _____

Policyholder's Full Name:_____ Policyholder's Date of Birth: _____/_____/_____

Insurance ID Number:_____ Group Number: _____

Employer if Group Plan:_____ Policyholder's Relationship to Patient: _____

Secondary Insurance Company: _____Effective Date:_____

Policyholder's Full Name: _____ Policyholder's Date of Birth: _____/_____/_____

Insurance ID Number:_____Effective Date of Plan: _____/_____/_____

Employer if Group Plan: _____ Policyholder's Relationship to Patient: _____

The **Financial Guarantor** (person who receives billing statements) is the parent that signs the financial policy and brings the child in for medical services.

Does this apply to all children? _____ (If no, provide other necessary information here.)

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Contacts

	Primary Parent	Secondary Parent
Full Name		
SSN		
Relationship to Patient(s)?		
Resides with Patient(s)?		
Street Address		
Address: City, State, Zip		
Birth Date		
Primary Phone:		
Work Phone:		
Cell Phone:		
Email: Must be unique to Contact		
Contact may have access to Patient Portal for all children? (Yes or No)		
Is this Contact preferred for reminders?		
Preferred method of Contact (Circle one preference for each reason)	**Apt Reminders:** Text-Cell Call-Prim Phone Email **Medical Issues:** Text-Cell Call-Primary Phone **General Info:** Text-Cell Call-Cell Email **Statements:** Text-Cell Mail	**Reminders:** Text-Cell or Email **Medical Issues:** Call-Cell Text-Cell Call- Cell **General Info:** Call-Cell Text-Cell Email

- *If Patient is 18 or older, Include Contact Info for Patient. Please use another form if more Contact space is needed.*

Emergency Contact for listed children (other than Contacts listed above):

Name _____Relationship to Patient(s) _____Phone (_____) ____-_____

Please list anyone else authorized to be your representative and bring your child(ren) to appointments:
I understand I can change or revoke the below authorization at any time but I can't change or revoke names given by another parent.
Name _____Relationship to Patient(s) _____Phone (_____) ____-_____

Name _____Relationship to Patient(s) _____Phone (_____) ____-_____

I have reviewed copies of the **Financial Policy, Missed Appointment Policy** and **Notice of Privacy**, and these notices are available in the office and on our website. Copies are available upon request. I understand both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. I understand if there are Custody Orders in place, I must present current copies for my child's file. I authorize the people listed to bring my child(ren) to any appointments in my absence and Grace Pediatrics may call and leave a message regarding my child's clinical care, including lab and x-ray results in my absence. I understand this authorization for release of information will remain in effect until parent or guardian changes their disclosure with Grace Pediatrics in writing. At that time this authorization will expire. I authorize Grace Pediatrics, only upon my request, to fax any forms or immunizations records to my child's school. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners. I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Grace Pediatrics. I understand Grace Pediatrics provides immunization information to the Tennessee State Immunization Information System, and I may opt out of having my child's information sent by notifying Grace in writing. I understand that I am personally responsible for being aware of the dates and times of my scheduled appointments.

Signature _____Relationship to Patient(s) _____

Date _____Employee_____