Olney Pediatrics - Patient Demographics

PATIENT'S LEGAL First Name_____ Mid. Initial_____ Last _____

Date of Birth_____ **Circle one:** Male Female Nickname_____

Parent 1 Name_____ Date of Birth_____

Occupation _____ Employer _____

Parent 2 Name_____ Date of Birth_____

Occupation _____ Employer _____

Patient's Home Address_____ City_____ State_____ Zip Code_____

Child lives with(**circle one**): Both parents(same address) Mother only Father only Both parents(separate addresses) Other

Are the home address and billing address the same?(**circle one**) Yes **If No (enter billing address below)**

Name of Responsible Bill Payer (For balances after insurance)_____

Billing Address_____ City_____ State_____ Zip Code_____

Primary phone # for Confirmations & Contact_____ **Circle one**: Home Mom cell Dad cell Other?

2nd phone number_____ **Circle one:** Home Mom cell Dad cell Other? _____

3rd phone number_____ **Circle one:** Home Mom cell Dad cell Other?_____

4th phone number_____ **Circle one:** Home Mom cell Dad cell Other?_____

Email address_____ Owner of this email_____

Because we receive vaccines from the State of Maryland. The manner in which the State breaks down its distribution information requires us to ask the following:

Race (please circle ALL that apply):

White American Indian/Alaskan Native Asian Black/African American Native HI/Pacific IS Prefers not to answer

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Prefer not to answer

Preferred Language other than English_____

Primary Insurance Company Name_____ Copay_____

Member ID #_____ Group number_____

Subscriber's Name_____ Birth date_____ Start Date_____

Employer_____

Secondary Insurance Company Name _____ Copay_____

Member ID #_____ Group number_____

Subscriber's Name_____ Birth date_____ Start Date_____

Employer_____

Insurance Authorization and Assignment and HIPAA (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and authorize him/her to furnish information regarding my visits to my insurance carrier for claims processing.

I understand that I am responsible for my bill unless this form is complete

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding the protected health information of my children (or myself if I am a patient 18yrs or older). I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Parent/Guardian Signature_____ Relationship_____ Date _____