Primary Doctor: ______________________________

Child's Name: ____ Gender (Please Mark One): _____M_____F
(First) (Middle) (Last)

Date of Birth: ____________________ Place of Birth: ______________________________
(mm / dd / yyyy) (City and State)

Home Address: ____
(Street) (City) (State) (Zip)

If you experience a move throughout our care for your child please update this information with your home office.

Mother/Guardian's Name: ______________________________ **DOB**: _______________ **SSN**: _______________

Occupation: ____________________________________ Employer: ______________________________

Home#: ____________________ **Cell#**: ______________________ **Alternate #**: ______________________

Primary Phone Number (Please Mark One) Home# ☐ Cell # ☐ Alternate # ☐

Email Address: ____

Father/Guardian's Name: ______________________________ **DOB**: _______________ **SSN**: _______________

Occupation: ____________________________________ Employer: ______________________________

Home#: ____________________ **Cell#**: ______________________ **Alternate #**: ______________________

Primary Phone Number (Please Mark One): Home# ☐ Cell # ☐ Alternate # ☐

Email Address: ____

Primary Insurance: ______________________ Policy Number: ____________________ Group #: _______________

Policyholder's Name: ______________________________ DOB: _______________ SSN: _______________

Secondary Insurance: ____________________ Policy Number: ____________________ Group #: _______________

Policyholder's Name: ______________________________ DOB: _______________ SSN: _______________

Sibling's Names and Dates of Birth:

1.) ____________________________ DOB: __________ **3.)** ____________________________ DOB: __________

2.) ____________________________ DOB: __________ **4.)** ____________________________ DOB: __________

5.) ____________________________ DOB: __________ **6.)** ____________________________ DOB: __________

Emergency Contact

Name: ____ Phone Number: ______________________

Relationship to Patient: ____________________________________

Demographic Information

The Federal Government requires all medical practices to collect the following information from patients.
There is a provision in the law that allows patients to not answer these questions.
Please answer the following three questions or select the "I decline to provide this information" answer.

1.) My Child's Ethnicity is: (Please Select One)
A. Hispanic or Latino
B. Not Hispanic or Latino

2.) My Child's Race is: (Please Select One)
A. American Indian/Alaskan Native
B. Asian
C. Black or African American
D. Native Hawaiian or Pacific Islander
E. White/Caucasian
F. Other

3.) My Child's Preferred Language is: (Please Select One)
A. English
B. Spanish
C. Other: ______________________________
(Please Provide Preferred Language)

☐ I decline to provide this information

Child's Birth History

Born at(Name of Hospital): ______________________________

Type of Delivery (Please Select One): ☐ Vaginal ☐ C-Section
NICU(Please Select One): Yes No If Yes, Reason for NICU Hospitalization: ______________________________

Your Rights and Responsibilities

- I have a right to be seen in a timely manner. I will be informed of any delay, and I have the right to reschedule if a delay is too lengthy.
- I will be informed of my child/children's test results in a timely manner.
- I agree to be on time for my appointments and will pay a missed appointment fee for any appointment I miss if I fail to notify the office at least 8 hours in advance. Three or more missed appointments per family may also lead to dismissal.
- I understand that I am responsible for understanding the benefits of my insurance plan. It is my responsibility to determine what services are covered and/or not covered by my insurance plan. I understand that Palmetto Pediatrics does not provide care based on what my insurance does or does not cover. I hereby assign my insurance benefits to Palmetto Pediatrics and Adolescent Clinic, PA.
- I understand that copayments are to be taken at check-in for any appointment and failure to pay the copayment amount at this time will result in a Billing Fee.
- I am ultimately responsible for the payment of the services my child/children receive. I understand that my co-payment, co-insurance and deductible are due at the time services are rendered. Palmetto Pediatrics accepts cash, checks, Visa, Master Card and Discover.
- I understand that any questions or disputes about my bill must be addressed with the Billing Department (803-788-6146). I understand that if I cannot afford to pay in full a bill I receive, it is my responsibility to contact the Billing Department to set up a monthly payment plan.
- I understand that Palmetto Pediatrics participates in the VFC program and that I am responsible for determining whether or not my child/children are eligible to receive vaccines through VFC.
- I understand that there is a charge for copying medical records.
- I understand that there may be a charge for completion of physical, camp, school and FMLA forms.
- I agree to pay a returned check fee for any check that is returned from my bank for insufficient funds.
- I understand that if owe Palmetto Pediatrics a balance on my account for greater than 150 days I may be turned over to a collections agency. I agree to pay all costs related to assigning my account to an outside collections agency. I understand that if I am turned over to an outside collection agency I will be dismissed from all SCPA businesses.
- I understand that Palmetto Pediatrics can only bill for the diagnoses and procedures documented in my child/children's medical records and that to ask the doctor to change a diagnosis or procedure to secure insurance payment constitutes fraud.

Name of person filling out this form (printed): ______________________________

Parent/Guardian Signature: ______________________________ **Date:** ______________