Lake Worth Pediatrics

PATIENT INFORMATION

Name of Child: _____ Age: _____ Sex: M ☐ F ☐

Date of Birth: _____ Nickname: _____ Child's SS#: _____

Mother's Name: _____ Father's Name: _____

Primary Caretaker: _____ Relation to child: _____ Driver License #: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Primary Language Spoken: _____

Besides parents/guardian who else is authorized to bring the child for medical treatment?

_____

Relation to the Child: _____

Other Siblings:

1. First Name: _____ Last Name: _____ Date of Birth: _____

2. First Name: _____ Last Name: _____ Date of Birth: _____

INSURANCE INFORMATION

Primary Insurance Information ***Name of Insurance:*** _____

Person Financially Responsible: _____ Name of Primary Insured: _____

Primary Insurance Holder: Mother ☐ Father ☐ Guardian ☐ Other ☐

Date of Birth of Primary Insurance Holder: _____ Driver License #: _____

Plan Name: _____ Policy Number: _____

Group Number: _____ Employer: _____

Employer's Address: _____

EMERGENCY CONTACT

In the event of Emergency whom shall we contact?

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Release and Assignment

I certify that my minor/child is covered by insurance with _____ (Carrier name) and is assigned directly to Dr. Shankaraiah/ Dr. Pallavi Shankaraiah/ Alyssa Witters, APRN/ Anna Klimowska, APRN at Lake Worth Pediatrics for all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payments and benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I, the undersigned, and parent/guardian of _____ (child), hereby authorize the providers at Lake Worth Pediatrics to provide any and all medical treatment for the above patient as they in their discretion see fit. I understand that Lake Worth Pediatrics recommends engaging in telehealth services with me to provide treatment. I understand the information regarding telehealth, and I hereby give informed consent to the use of telehealth. The authorization shall be deemed effective as of _____ (Today's date) and shall remain in effect until terminated by the undersigned.

_____ _____

Signature of Parent/Guardian Date