Ballentine Pediatrics Demographic Questionnaire

PLEASE COMPLETE ALL SECTIONS BELOW

Patient Information

Patient's Full Name _____ Date of Birth ___/___/_____
First Middle Last

Address _____ Apt/Lot #_____ City _____ Zip _____

Home Phone # _____ Patient's SS# _____-_____-_____ Male or Female

Preferred Language_____ Ethnicity: Hispanic/Latino (circle one) Yes or No

Race: _____ African American/Black _____ American Indian/Alaskan Native _____ White

_____Other Race (please specify) _____

Parent Information

Father's Name _____ Date of Birth ___/___/___ SS# ___-___-_____

Employer _____ Work #_____ Cell #_____

Mother's Name _____ Date of Birth: ___/___/___ SS# ___-___-_____

Employer _____ Work #_____ Cell #_____

Insurance Information

Primary Insurance _____ Effective Date ___/___/___ ID_____

Policy-Holder's Name: _____ Date of Birth: ___/___/___ Relationship to patient_____

Employer _____ Group #_____

Secondary Insurance _____ Effective Date ___/___/___ ID_____

Policy-Holder's Name: _____ Date of Birth: ___/___/___ Relationship to patient_____

Employer _____ Group #_____

Responsible Party Information

Responsible Party Name _____ Relationship to Patient _____

Address _____ Apt/Lot #_____ City _____ Zip _____

Home # _____ Work # _____ Cell # _____

Sibling Information (Brothers and Sisters) *If additional space is needed continue on the back of page.*

First Name	Last Name	Date of birth	Sex

I hereby assign all medical and surgical benefits to which I am entitled and authorize and direct my insurance carrier to issue payment directly to BALLENTINE PEDIATRICS, LLC for services rendered. I hereby authorize the release of any medical information necessary to process insurance claims. I understand that I am responsible for any amount not covered by insurance.

Signature Relationship to Patient Date

Thank you for allowing us to be a partner in your children's healthcare.

PHI Consent Form

Child's Name **Date of Birth**

Emergency Contact:_____Relationship_____Phone#_____

Preferred Pharmacy (**Include location**): _____

Preferred Phone# for Messages and Appointment Reminders: (_____)_____

Preferred Email: _____ Mother____ Father____ Other_____

Secondary Email: _____ Mother____ Father____ Other_____

Patient Portal: Ballentine Pediatrics offers a patient portal that allows you access to your child's medical information. Would you like access to this information? YES_____ NO_____

Consent for Disclosing Protected Health Information

I, _____ authorize Ballentine Pediatrics to disclose the following "Protected Health Information": Doctor's Excuse_____ Immunization Record_____ Permission for Medication____ for my child listed above.

I understand that there is an increased risk for an unauthorized person to receive my "Protected Health Information. Please select the method(s) that you authorize Ballentine Pediatrics to share your child's information upon your verbal request.

School/Daycare: Name_____Fax_____ **(initial)** ___

School/Daycare Location:_____

Work or Personal Email: _____ **(initial)** ___

Work or Personal Fax:_____ **(initial)** ___

Print Name of Parent/Guardian Relationship

Signature Date

Ballentine Pediatrics 11134 Broad River Road Suite D Irmo, SC 29063

Patient Name: _____D.O.B._____

Acknowledgment and Authorization:

- I have read and understand the HIPAA/Privacy Policy for BALLENTINE PEDIATRICS LLC

signed: _____ Date: _____

- I hereby assign my INSURANCE BENEFITS to be paid directly to BALLENTINE PEDIATRICS LLC

signed: _____ Date: _____

- I authorize BALLENTINE PEDIATRICS LLC to release medical information required to process my claim

signed: _____ Date: _____

- I have read and understand the FINANCIAL POLICY for BALLENTINE PEDIATRICS LLC

signed: _____ Date: _____

- I authorize BALLENTINE PEDIATRICS LLC to obtain/have access to my MEDICATION HISTORY

signed: _____ Date: _____

- I authorize BALLENTINE PEDIATRICS LLC to contact me on my mobile phone

signed: _____ Date: _____