PATIENT INFORMATION: GENDER: M / F BIRTH DATE: ______________________________

NAME: ____ PATIENT CELL PHONE: ______________________
(If none leave blank)

STREET ADDRESS: ____ CITY: ______________________________

STATE: ______________ ZIP: _________________ HOME PHONE: ____

PARENT INFORMATION:

PARENT # 1 NAME: ______________________________________ HOME PHONE: ____________________________

CELL PHONE: ____ LIVES WITH PATIENT: Y / N

EMPLOYER/OCCUPATION: ____ DATE OF BIRTH: ______________

EMAIL ADDRESS: ____ Would you like this as the *Primary* Email? Y / N

PARENT # 2 NAME: ______________________________________ HOME PHONE: ____________________________

CELL PHONE: ____ LIVES WITH PATIENT: Y / N

EMPLOYER/OCCUPATION: ____ DATE OF BIRTH: ______________

EMAIL ADDRESS: ____ Would you like this as the *Primary* Email? Y / N

REFERRED BY: ____

EMERGENCY CONTACT: ____

PHONE: ____ RELATIONSHIP TO PATIENT: _________________

I authorize the providers of Morningside Pediatrics to provide medical treatment for my child on an ongoing basis, until this consent is revoked. I also allow the individuals on the back of this form to provide consent for my child. I consent in the event that my child, once over 14 years of age, arrives unaccompanied by an adult.

I authorize the release of any medical information necessary to process this claim, and future claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Morningside Pediatrics to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company be made directly to Morningside Pediatrics. I certify that the information I have reported with my insurance coverage is correct. In the event that a service or product is not covered by my insurance, I understand that I will be personally responsible for payment. This authorization may be revoked by either me or the insurance company at any time, in writing. I understand that my records may be copied and transferred upon written request, for a $35 fee. I understand that there is a $25 fee for a missed appointment or appointments canceled with less than 24 hours notice.

SIGNATURE: ____ DATE: ____________________________

I, ___________________________________, have reviewed a copy of Morningside Pediatrics' "Notice of Privacy Practices".

SIGNATURE: ____ DATE: ____________________________