WMC WILMER MEDICAL CLINIC

Pediatric

Patient Demographic Information

Patient's Name _____

First **Middle Initial** **Last**

Date of Birth: _____ **Social Security #:** _____

Gender: Male or Female **Race:** _____ **Ethnicity:** Hispanic Non- Hispanic Other

Home Phone #: _____ **Cell Phone #:** _____

Preferred Method of Contact: _____ **Ok to leave Message:** Yes No

Email Address: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (**if different**): _____

City: _____ State: _____ Zip Code: _____

Information regarding Parent/Guardian/Legal Representative

Mother's Name _____

Date of Birth: _____Social Security #: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____ Work Phone #: _____

Father's Name _____

Date of Birth: _____Social Security#:_____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____ Work Phone #: _____

Emergency Contact Name: _____

Phone #: _____Relation:_____

Preferred Pharmacy Information Pharmacy on file for medications and refills

Name: _____ Phone #: _____

Primary Insurance: _____

Policy #: _____ **Group #:** _____

Name of Primary Insured: _____ **Relation to patient:** _____

Primary Insured Date of Birth: _____ **Social Security #:** _____

Secondary Insurance **(If Any):** _____

Policy #: _____ Group #: _____

Name of Primary Insured: _____ Relation to patient: _____

Primary Insured Date of Birth: _____ Social Security #: _____

I give permission for the following individuals other than parent/legal guardian listed on the above page to bring my child to Wilmer Medical Clinic for medical treatment: (Must also include emergency contact)

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Please List any siblings who are also patients at WMC: _____

_____

Financial Responsibility

Payment is due at the time of service. I understand I will be expected to pay any deductibles, co-payments, and fees at the time of any office related service. I will be responsible for any patient balances after insurance has been filed. I understand that Wilmer Medical Clinic has the right to refer my account to an outside collection's agency after a period of 90 days.

Initial: _____

Consent to Treat

I hereby give authorization to all the physicians and staff at Wilmer Medical Clinic to treat my minor child or myself. I hereby give authorization for payment of insurance benefits to be made to Wilmer Medical Clinic for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance. In case of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare facility to release all information necessary to secure payment of benefits and that a photocopy of this agreement shall be as valid as the original.

Initial: _____

Electronic Communications

WMC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the email address you provide to us.

Initial: _____

MEDICAL TREATMENT CONSENT FORM

The undersigned _____ do hereby authorize or such substitute as

Parent or Legal Guardian's Name

he/she may designate as agent for the undersigned to consent to any X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care for _____

Minor's Name

which is deemed advisable by and to be rendered under the general or special supervision of any and/ or surgeon, licensed under the Provision of Medical Care Practice Act whether such diagnosis or treatment is rendered at the office of said physician, at a hospital, or elsewhere.

_____ _____

Parent or Legal Guardian Signature **Date**

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Wilmer Medical Clinic's Notice of Privacy Practices ("Notice"):

- It tells me how WMC will use my health information for the purpose of medical treatment, payment for treatment, and WMC's health care operations.
- The notice explains in detail my individual rights and how I may exercise these rights.
- WMC will also use and share my health information as required/permitted by law.

This consent is valid for one year from the date listed below.

Patient's Complete Legal Name: _____

(Please Print)

Patient's DOB: _____ **Date:**_____

Signature: _____ **Witness:**_____

(Parent or Legal Guardian)