

NEIGHBORS PEDIATRICS

1871 Savage Road Charleston, S.C. 29407
105 Springhall Dr Goose Creek, S.C. 29445
1818 Remount Rd Hanahan, SC 29410
Ph: (843) 766-6308

Patient Information

First Name: _____ Sex: Male _____ Female _____
Last Name: _____ Date of Birth: ____ / ____ / ____ Age: _____ SSN: _____
Middle Initial: _____ Preferred Name: _____
Address: _____ City: _____ County: _____ State: _____ Zip: _____
Can we notify you of appointments and normal test results by phone or text messaging? Yes ____ No ____
Primary cell number for text reminders () _____
Primary Caregiver's email address: _____ Primary Care Physician: _____
Referred by: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino
Primary Language: English Spanish French Other: _____
Race: Caucasian Afr. American Asian Native Hawaiian/Pacific Islander Hispanic Other: _____
Pharmacy name: _____ Address: _____ Phone: () _____
Primary Insurance: _____ Secondary Insurance: _____
Insurance Policy Holders DOB: _____
Emergency Contact: Name: _____ Relationship: _____ Phone: () _____
(other than parents)

Mother/Father/Other Information

Mother: Last Name: _____ First Name: _____ Middle: _____ Mrs. Ms. Miss
Date of Birth: ____ / ____ / ____ Age: _____ SSN: ____ - ____ - ____
Address (If different from Patient): _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____
Financially Responsible: Yes No

Father: Last Name: _____ First Name: _____ Middle: _____
Date of Birth: ____ / ____ / ____ Age: _____ SSN: ____ - ____ - ____
Address (If different from Patient): _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____
Financially Responsible: Yes No

Other: Last Name: _____ First Name: _____ Middle: _____ Mr. Mrs. Ms. Miss
Date of Birth: ____ / ____ / ____ Age: _____ SSN: ____ - ____ - ____
Address (If different from Patient): _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____
Financially Responsible: Yes No

OVER →

Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR ANOTHER INDIVIDUAL WITH WHOM THE PROVIDER? MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below.)

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. *For example, you may list family members, friends, or other caregivers. *This documentation is valid for one year only.*

Parents do not need to be listed in this section, unless child is 18 or older

Name of person

Relationship to Patient (example: Grandfather)

An **Authorization to Release Information Form** must be completed for all releases and disclosures not listed in the section below. A **Request for Restrictions Form** must be completed to request restrictions of the use of your information.

Authorization, Assignment of Benefits, and Referral Medical Release

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Neighbors Pediatrics Notice of Information Practices, which a copy will be provided upon request.

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Neighbors Pediatrics for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient's Signature (unless minor) _____

Date: _____/_____/_____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____

Date: _____/_____/_____