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PORT CITY PEDICATRICS - PATIENT UPDATE

Please fill out completely. This information will help us better serve our patients and help the billing process.

Patient's full name: _____ Today's date:_____

Date of birth: _____ Male ☐ Female ☐ Your Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred method of contact: Email ____ Mail ____ Text ____ Voicemail ____

Emergency Contact: name, phone number and relationship to patient:_____

Since last year's well exam, have there been any changes in patient's health, changes at home, or changes in family history ? Yes ☐ No ☐

If yes, please list:_____

Preferred Pharmacy/location: _____

Who has guardianship of this patient? Mother ☐ Father ☐ Both ☐ Foster ☐ Other ☐

Mom's name:_____ Date of Birth:_____ Place of Employment:_____

Dad's name:_____ Date of Birth:_____ Place of Employment:_____

If "Other," list name and relationship:_____

Have there been any changes in insurance coverage/policy? Yes ☐ No ☐ **If yes, complete below:**

Who carries the **primary** insurance? _____ SSN: _____

Address of parent/guardian if different from patient address: _____

Name of insurance/contract number: _____

Who carries the **secondary** insurance? _____ SSN: _____

Address of parent/guardian if different from patient address: _____

Name of insurance/contract number: _____

****If Consent to Receive Medical Information has changed, please ask Receptionist for a new Consent form.**

FINANCIAL AUTHORIZATION

I authorize payment of medical benefits to Richard Golz, M.D. and/or Elizabeth Pallante, M.D. and/or Karl Nicles, M.D. and/or Alison Fox, M.D. and/or Paul Alban, M.D. and/or Dustin Miller, M.D. and/or Jessica Pedersen, M.D. I authorize release of all information necessary to process insurance claims and to secure payment. I understand that my signature requests that payment be made, and I authorize release of medical information necessary to pay the claim. A photocopy of this assignment is to be considered as valid as the original. I further understand that I am financially responsible for all charges whether or not paid by my insurance.

By checking the box and providing my email address as an authentication, I am providing an electronic signature certifying that the above statements true.

☐ Email address: _____

Signature: _____ Date: _____

DIVORCED PARENTS: A copy of your divorce decree is required for your child's chart that states which parent has physical custody, one or both; which parent is financially responsible for medical care; whose insurance is primary and whose insurance is secondary.

Revised 05-03-2019