



PATIENT DEMOGRAPHIC INFORMATION - PEDIATRIC

Please Complete This Entire Form. Thank You!

Today's Date: ___/___/___

Referred by (If Applicable): _____

CHILD INFORMATION

OFFICE USE (P#): _____

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	DATE OF BIRTH (mm/dd/yyyy):	
MAILING ADDRESS:			CITY:	STATE:	ZIP:	
PHYSICAL ADDRESS (If different from mailing address):			CITY:	STATE:	ZIP:	
HOME PHONE: ()	CELL PHONE: ()		WORK PHONE: ()		EXTENSION:	
E-MAIL ADDRESS: <input type="checkbox"/> None <input type="checkbox"/> Prefer Not To Disclose			USE E-MAIL ADDRESS FOR PATIENT PORTAL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		SOCIAL SECURITY # (If applicable):	
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown		RACE: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refuse to Report <input type="checkbox"/> Other				
ETHNICITY: <input type="checkbox"/> Hispanic/Latin <input type="checkbox"/> Non-Hispanic/Latin <input type="checkbox"/> Refuse to Report			PREFERRED LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Please specify):			

PARENT/LEGAL GUARDIAN #1 - GUARANTOR

(Individual responsible for bills and payment)

OFFICE USE (Account #): _____

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	RELATIONSHIP TO CHILD (Check all that apply): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (Please specify):	
STREET ADDRESS: <input type="checkbox"/> Check if same as patient			CITY:	STATE:	ZIP	
HOME PHONE: ()	CELL PHONE: ()		WORK PHONE: ()		EXTENSION:	
E-MAIL ADDRESS: <input type="checkbox"/> None <input type="checkbox"/> Prefer Not To Disclose			SOCIAL SECURITY #:		DATE OF BIRTH (mm/dd/yyyy):	
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown		EMPLOYER NAME:		EMPLOYER PHONE #: ()		

PARENT/LEGAL GUARDIAN #2

LAST NAME:		FIRST NAME:		RELATIONSHIP TO CHILD (Check all that apply): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Primary Care Giver <input type="checkbox"/> Other (Please specify):		
STREET ADDRESS: <input type="checkbox"/> Check if same as patient			CITY:	STATE:	ZIP:	
HOME PHONE: ()	CELL PHONE: ()		WORK PHONE: ()			

EMERGENCY CONTACT

LAST NAME:		FIRST NAME:		RELATIONSHIP (Please specify):	
HOME PHONE: ()	CELL PHONE: ()		MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: <input type="checkbox"/> Yes <input type="checkbox"/> No		

ADDITIONAL CONTACT (OPTIONAL)

LAST NAME:		FIRST NAME:		RELATIONSHIP TO CHILD (Check all that apply): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Primary Care Giver <input type="checkbox"/> Other (Please specify):	
HOME PHONE: ()	CELL PHONE: ()		MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: <input type="checkbox"/> Yes <input type="checkbox"/> No		

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: <input type="checkbox"/> Yes <input type="checkbox"/> No (Self Pay)					
PRIMARY INSURANCE:			SECONDARY INSURANCE:		
SUBSCRIBER:		RELATION:		SUBSCRIBER:	
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown		GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown			
DATE OF BIRTH (mm/dd/yyyy):		SOCIAL SECURITY #:		DATE OF BIRTH (mm/dd/yyyy):	
				SOCIAL SECURITY #:	

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

CONFIDENTIAL COMMUNICATION – Please leave messages regarding my protected health information as follows (**Check All That Apply**):

- | | | | |
|-----------------------------------------------|------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Home Phone of Record | <input type="checkbox"/> Voicemail | <input type="checkbox"/> Text | <input type="checkbox"/> Mailing Address of Record |
| <input type="checkbox"/> Cell Phone of Record | <input type="checkbox"/> Voicemail | | <input type="checkbox"/> Other Address: _____ |
| <input type="checkbox"/> Work Phone of Record | <input type="checkbox"/> Voicemail | | Street City State Zip |

Receipt of Notice of Privacy Practices

I have been offered the COPC Notice of Privacy Practices which outlines how my Protected Health Information may be used and disclosed, and how I can get access to the information. Yes No Offered but Decline Initials: _____

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. Accept Decline Initials: _____

Telephone Contacts, Monitoring and Recording-this does not include calls related to appointments, billing or health-related information

I have established a relationship with COPC and agree that COPC (or anyone working on behalf of COPC) may text, e-mail or use an automated dialing service to: (1) contact me regarding my most recent visit with my provider; and (2) inform me about new services or suggested health screenings. I understand these calls may be monitored or recorded and, if I accept now, I may opt-out at any time by responding “Opt-Out” on the message. Accept Decline Initials: _____

Health Information Exchange (HIE)

COPC participates in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that my COPC provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the COPC EHR Department or my physician.

All COPC patients are automatically enrolled in the HIE unless the Opt-Out box is checked and initialed. Opt-Out Initials: _____

Confidential Communications

I understand COPC will notify me if COPC is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to COPC or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.

I certify that I will pay to COPC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to COPC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

Pharmacy Consult Agreement

A pharmacist may be utilized in the management of your care pursuant to a consult agreement between your COPC provider and a pharmacist. You may elect to withdraw from such consult agreement at any time.

General Consent for Treatment

I have selected Central Ohio Primary Care Physicians, Inc. as my medical provider **[for myself and my minor children as identified to COPC]** (referred to collectively as “I”, “me” and “my”). I am presenting to COPC, and I consent to the services, treatments, and procedures performed and ordered by my physician(s) and other healthcare providers, which may be performed during an episode of care, including, but not limited to, those rendered in person and via electronic means such as telemedicine. I acknowledge that medicine is not an exact science, my diagnosis and treatment may involve risk of injury or even death, and no guarantees can be made to me as to the results of examinations or treatments during any episode of care, and I elect to receive Services with full understanding of this information and these potential risks.

By signing below, I am acknowledging that I have read and understand the above statements.

Parent or Legal Guardian Printed Name

Parent or Legal Guardian Signature

Date Signed

• **PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT’S RECORD**