PLANTATION PEDIATRICS
1871 Savage Road Charleston, S.C. 29407
105 Springhall Rd Goose Creek, S.C. 29445
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: ( )_____

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*.

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 Plantation 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 Plantation 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:_____/_____/_____