



## New Patient Form

### Child's Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Birth Date: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: Male / Female (Please Circle)

Parent's Name(s): \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Pharmacy with address: \_\_\_\_\_

### Financially Responsible Party

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_



**HIPAA Disclosure Form**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

(Please Circle)

May we identify ourselves over the phone? Yes / No

May we leave voice messages? Yes / No

May we send text notifications? Yes / No If yes, what phone number \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Kids First Children’s Urgent Care to release my dependent’s medical information (appointments, labs, x rays, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family member:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

I further release my medical information to the following physicians, clinics, hospitals and/or schools:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Please list anyone that may be bringing the patient to appointments and thier relationship to the patient:

\_\_\_\_\_  
\_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Signature Date: \_\_\_\_\_



**History Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

**Medical History (Please Circle)**

ADHD	Congenital Heart Disease	Frequent Ear Infections
Acne	Concussions	Frequent UTI's
Asthma	Diabetes	GERD
Bleeding Disorders	Eczema	Heart Murmur

Vaccinations Status (circle one) Vaccinated / Unvaccinated Partial / Up to date

ANy recent exposures? No / Yes if yes explain \_\_\_\_\_

Other: \_\_\_\_\_

**Surgical History (Please specify month and year)**

Appendectomy \_\_\_\_\_ Circumcision \_\_\_\_\_ Reduction of Fracture \_\_\_\_\_

Adenoidectomy \_\_\_\_\_ Dental \_\_\_\_\_ Hernia \_\_\_\_\_ Tonsillectomy \_\_\_\_\_

PE tubes \_\_\_\_\_

**Family History (Please specify which family member has a condition)**

Asthma \_\_\_\_\_ Heart Disease \_\_\_\_\_ Obesity \_\_\_\_\_

Birth Defects \_\_\_\_\_ HighCholesterol \_\_\_\_\_ Seizure Disorder \_\_\_\_\_

Cancer \_\_\_\_\_ Hypertension \_\_\_\_\_ SIDS \_\_\_\_\_

Diabetes \_\_\_\_\_ Mental Illness \_\_\_\_\_ Thyroid Disease \_\_\_\_\_

**Social History**

Does anyone smoke inside or outside the home? \_\_\_\_\_

Number of adults in the household? \_\_\_\_\_

Number of children in the household? \_\_\_\_\_

Number of pets in the household? \_\_\_\_\_



## Patient Financial Responsibility Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This form outlines our financial policy and your responsibilities regarding payment for the services we provide. We are committed to providing you with the highest quality of care and transparent billing practices. Please, initial, and sign below.

### **Insurance and Coverage:**

- It is your responsibility to understand your insurance benefits, including whether we are an in-network or out-of-network provider. You are also responsible for knowing your plan's specific requirements, such as co-pays, deductibles, and co-insurance.
- You are responsible for notifying our office of any changes to your insurance coverage or personal information in a timely manner.
- If you have not met your Insurance deductible at time of service \$50 will be collected to go towards your deductible. Any remaining deductible charges will be billed to you.

### **Payment for Services:**

- Payment is due at time of service. All co-payments, Co-Insurance payments and payments for services not covered by your insurance are due at the time the services are rendered.
- You are financially responsible for any services deemed "not medically necessary" or non-covered by your insurance carrier

### **Past Due Accounts and Collections**

- You are responsible for paying any balance not covered by your insurance after your claim has been processed.
- If your account becomes delinquent, we reserve the right to engage a third-party collection agency. In this event, you will be responsible for any additional collection fees, legal costs, and attorney's fees incurred.

### **Consent and Acknowledgment**

By signing below, I acknowledge that I have read, understood, and agree to the financial policies of KidsFirst Children's Urgent and Primary Care. I agree to be financially responsible for all services rendered to me or my dependent(s).

Printed Name (Patient): \_\_\_\_\_

Printed Name (Responsible Party, if different): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

