Alamo Heights Pediatrics - Patient Demographic Info.

PATIENT LEGAL Name :_____ **Male/Female** **Date of birth:**_____

SSN:_____ **Name Child Would Like to Be Called (if different from above):**_____

***Address:**_____ **City/State/Zip:** _____

In compliance with Federal HIPPA Privacy Regulations, will you authorize Alamo Heights Pediatrics to leave a detailed message on your answering machine/voicemail or text that may include appointment reminders, lab and x-ray results, referral information, and other private information protected by privacy rules.

Text & Voicemail Consent Authorization YES or NO ← *CIRCLE ONE*

Main contact phone #: _____ **Secondary phone #:** _____

Email: _____

Parent 1 Name:_____ **Parent 2 Name:**_____

Address:_____ **Address:**_____

City/State/Zip:_____ **City/State/Zip:**_____

SSN:_____ **DOB:**_____ **SSN:**_____ **DOB:**_____

Primary Phone:_____ **Primary Phone:**_____

Employer:_____ **Employer:**_____

***Siblings*:**

Name: _____ **Date of Birth:** _____ **Name:**_____ **Date of Birth:**_____

Name: _____ **Date of Birth:** _____ **Name:**_____ **Date of Birth:**_____

Name: _____ **Date of Birth:** _____ **Name:**_____ **Date of Birth:**_____

Authorized Family Members/Adults

It is the policy of Alamo Heights Pediatrics that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals, *other than parents*, are authorized to act in your place with respect to any and all medical matters. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

Name:_____ **Phone:**_____ **Relationship:**_____

Name:_____ **Phone:**_____ **Relationship:**_____

Responsible Party is the individual who agrees to accept financial responsibility for the payment of all services performed at Alamo Heights Pediatrics.

The individual may not necessarily be the insurance card holder. The responsible party must read and sign below.

Name:_____ Relationship to Patient:_____

Address (if different from above)_____ Social Security Number:_____

Phone # :_____ Email: _____

Parent/Guardian/Self:_____ **Date:**_____