Cleveland Pediatrics
"Where Kids Come First"
435 25th Street
Cleveland, TN 37311
Phone: (423) 479-9733
Fax: (423) 472-1890

Patient Information:

Date: _____ Preferred Language: English_____ Spanish _____

Child's Name: _____ Account #: _____

Birthday: _____ Please check one: Male ____ Female _____

Social Security #: _____ Race: _____

Name and Birthday of Siblings: _____

_____

Parent / Guardian Information:

Mother's Name: _____ Birthday: _____

Home phone #: _____ Cell phone # : _____

Street Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Work Phone # : _____ Social Security # : _____

Father's Name: _____ Birthday: _____

Home phone #: _____ Cell phone # : _____

Street Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Work Phone # : _____ Social Security # : _____

Insurance Information:

Primary Insurance:_____ Group No._____ ID No._____

Guarantor's Name:_____ Guarantor's DOB:_____

Secondary Insurance:_____ Group No. _____ID No._____

Guarantor's Name:_____ Guarantor's DOB:_____

Alternate Persons Allowed to Bring Child to Appointments:

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

Emergency Contact Information:

Name: _____ Relationship to child: _____

Address: _____ Phone # _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained for one of the following reasons:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining signature
- ☐ Emergency situation prevented us from obtaining signature
- ☐ Other (specify)

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Authorization and Release:

1. I authorize Cleveland Pediatrics providers to treat the named patient.
2. I understand that providing incorrect information can be dangerous to my child's health.
3. It is also my responsibility to inform the office of any changes in my child's medical status.
4. The above questions have been accurately answered.
5. I authorize the providers to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such medical care to third party payers and/or health practitioners.
6. I authorize and request my insurance company to pay directly to the physicians.
7. I understand that my medical insurance carrier(s) may pay less or none of the actual bill for services.
8. I agree to be responsible for payment of all services rendered on my behalf for my dependents.
9. I also authorize the medical staff to perform the necessary medical services (such as Vision, OAE, Hgb, urine etc.) and vaccines/injectables my child may need and agree to pay any of these charges not covered by my insurance company.
10. I agree to be responsible for any charges my insurance does not cover due to my failure to provide Cleveland Pediatrics current and accurate information in a timely manner.
11. If there is no insurance coverage or proof of coverage, I agree to pay the full amount at the time of service unless prior arrangements are made.
12. I certify that I have read and understand the above information to the best of my knowledge.

I understand that, if I have missed 3 or more appointments without notification to the practice, I will be dismissed.

Signature of Parent or Guardian

Date

Cleveland Pediatrics

TODAY'S DATE_____

I_____Give

CLEVELAND PEDIATRICS PERMISSION TO:

Please Check One: _____Leave Messages/Send Email

____ Person to Person Only

PATIENTS NAME_____

DATE OF BIRTH_____

PHONE NUMBER_____

PARENT/GUARDIANS SIGNATURE_____

EMAIL ADDRESS_____

PLEASE CIRCLE ONE: DO YOU PREFER APPT REMINDERS BY TEXT OR PHONE CALL

IS THERE ANY INFORMATION THAT YOU **DO NOT** WANT LEFT ON VOICE MAIL? **Y N**