PEDIATRIC ASSOCIATES
OF MT. CARMEL, INC.

offices in
Eastgate, Batavia, Landen

513-752-3650
pedsmtcarmel.com

Names of Children

Last Name	First Name	Middle Name or Initial	Date of Birth (DOB)	Social Security Number (SSN)	Sex M/F	Race	Ethnicity Hispanic/Latino Y or N	Preferred Language(s)

If you wish to decline to provide information about race, ethnicity, or language, please leave the box blank

Patient Address _____

City _____ State _____ Zip _____ County _____

Responsible Party Information/Additional Contact

Name	Name
DOB SSN	DOB SSN
Relationship to Patient	Relationship to Patient
Responsible Party? Y or N	Responsible Party? Y or N
Address	Address
City, State, Zip	City, State, Zip
Home Phone	Home Phone
Cell Phone	Cell Phone
Employed by	Employed by
Occupation	Occupation
Work Phone	Work Phone
Email Address	Email Address

Patient's Confidential Communication Preference

Contact Name _____

Method (circle): Cell Phone Work Phone Home Phone Email Text _____

provide phone number or email above

Emergency Contact (not living in home)

Name _____ Relationship _____ Phone Number _____

Insurance (copy of insurance card to be kept on file)

Name _____ Member # _____ Group # _____

I hereby assign all medical benefits to which the patient is entitled to Pediatric Associates of Mt. Carmel, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, paid or not paid, by said insurance. I also authorize Pediatric Associates of Mt. Carmel to evaluate and treat any and all medical conditions during this and subsequent visits. Updated 11/2021

Signature _____ Date _____