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
Email Address	Email Address
Occupation/Employer	Occupation/Employer
Add Portal Account (if not already established)? **Y** or **N**	Add Portal Account (if not already established)? **Y** or **N**

Phone Numbers

Primary Phone Number		Type (circle) HOME CELL WORK Relationship to Patient
Secondary Phone Number		Type (circle) HOME CELL WORK Relationship to Patient
Tertiary Phone Number		Type (circle) HOME CELL WORK Relationship to Patient

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. 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.

I **DO/DO NOT** consent to have the physicians and other staff at Pediatric Associates of Mt. Carmel communicate with me by phone and leave voicemail messages regarding various aspects of the medical care of the patients listed above, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I acknowledge I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted in writing to the Practice Manager/Privacy Officer.

Signature _____ Date _____