Date:

Baptist Health Pediatric Clinic

Patient Information

Patient's Full Name:____DOB::________________
Sex:_________
Address:
____
City:___________________________________State:__________________________Zip:_________________
_____
Race:__________________________Ethnicity:_________________________Religion:_________________

Phone:_____________________________________Email:____

Patient communication preference (Check all that apply)
Phone____Email____Text____MyChart____

Pharmacy:____SSN:__________________________

Circle the Doctor patient is seeing today: **DR. ROARK** **DR. VINSON**

Parent Information

Name:____
Relationship to patient:___________________
Social Security Number:_________________________Date of Birth:______________________________
Address:____Same as Patient: YES or NO

City:_________________________________State:_______________________Zip:______________________

Phone:_______________________________Email:____

Employer:____

Work Phone:________________________________

Additional Guardian/Guarantor Information

Name:____
Relationship to patient:__________________
Social Security Number:__________________________
Date of Birth:_________________________________
Address:____Same as Patient: YES or NO
City:________________________________State:________________________Zip:______________________
Phone:_______________________________Email:____
Employer:____Work #:_____________________________

Emergency Contact

Date:

Name:____
Relationship to patient:________________
Phone:____

Authorization to Treat my Child

List below any persons that you give permission to accompany your child for medical treatment (other than parent or guardian)

Name:___________________________Relationship:______________________Phone:_________________

Name:___________________________Relationship:______________________Phone:_________________

Name:___________________________Relationship:______________________Phone:_________________

Authorization, Consent and Acknowledgment

I hereby authorize my insurance benefit to be paid directly to Baptist Health Pediatric Clinic of Conway. I consent to the use or disclosure of my protected health information by Baptist Health Pediatric Clinic of Conway for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Baptist Health Pediatric Clinic of Conway. I have the right to revoke this consent in writing at any time, except to the extent that Baptist Health Pediatric Clinic of Conway has taken action in reliance to this consent. The notice of Privacy Practices for Baptist Health Pediatric Clinic of Conway has been provided to me.

Signature of Patient or Guardian:____
Date:__________________________________